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For August, 1937

Just in Passing—

Cover Page—Watkins Memorial Hospital, University of Kansas. Joseph Radotinsky, Topeka, Kan., state architect.

Looking Forward

THE EDITORS level a warning finger at administrators who dodge conferences with employees; regret the delayed baiting of trustees' interest in the A. H. A. convention; look hopefully toward a change in federal policy on hospitalization of charity cases and suggest a remedy for the nurse shortage.

City Health Center

No health center should plan to extend its services beyond that of a district depot for field work of the health department. HAVEN EMERSON, M.D., professor of public health practice, Columbia University, offers this view on the subject.

This Way to the Side Shows

A busman's holiday before or after the Atlantic City convention is suggested and, indeed, outlined by RAYMOND P. SLOAN, associate editor. His tour takes you through the medical centers and several hospitals of Greater New York, Jersey and Philadelphia.

Administrative Case Histories

E. MURIEL ANSCOMBE, administrator of the Jewish Hospital of St. Louis, suggests methods of handling two touchy situations—controlling visitors and getting doctors to complete medical case histories.

Looking at Labor Unions

DR. ARTHUR C. BACHMEYER, director of the University of Chicago Clinics and chairman of the Chicago Hospital Council's committee on personnel relations, summarizes a timely report on a contentious subject.

Constructed for the Crippled

WPA has lent a helping hand in the construction of several children's hospitals. HOWARD WHARTON of the periodicals section staff, WPA, tells about them in the first of a series of articles dealing with the rebuilding of government owned or supported hospitals.

They've Turned "Pro"

The new professional status of the medical technician and the ideals and future plans of this group are portrayed by FRIEDA CLAUSSEN of the Charles T. Miller Hospital, St. Paul, Minn.

That Laboratory Budget

In the second of a series of articles dealing with costs of the hospital laboratory, H. R. FISHBACK, M.D., gives facts on laboratory income obtained from a survey of forty-six hospitals. Doctor Fishback is on the staff of the department of pathology, Northwestern University Medical School.

Getting Good Social Workers

IRENE GRANT, chief of the social work section, U. S. Veterans Administration, believing that examinations and rigid civil service standards are the best means of maintaining high standards for medical social work, offers six pertinent suggestions.

Operating Room, New Style

The new operating unit at Cohoes Hospital, Cohoes, N. Y., FLORENCE H. HICKOK, the superintendent, describes with due pride.

ARE hospital

councils suited merely to large metropolitan areas? Or can this method of inter-hospital cooperation be made effective in smaller communities also? The Western New York Hospital Council thinks the answer to the second question is "Yes," and next month Moir Tanner, president, will tell how. The problems that now press upon hospitals demand more and more of cooperation if they are to be solved effectively. The hospital council, even when not fully implemented, can be a helpful tool in this problem-solving process.

ONE result of

council activity is presented in this issue—the summary by Dr. Arthur C. Bachmeyer of the report of the committee on personnel relations of the Chicago Hospital Council. It is an important report and Doctor Bachmeyer's summary should be read with care by all administrators, whether they are facing actual unionization of their employees or merely labor unrest.

NEXT month we

have an unusual treat in store. One of our "constant readers" has vigorously taken issue with us over the question of giving courtesy discounts to the professional staff. Safe on the deck of a liner bound for Ireland, he says we neglect the most important part of the question. You will enjoy Dr. Joseph Turner's article.

SHOULD every pa-

tient entering a general hospital have a routine x-ray? Yes, says Dr. Minas Joannides and gives cogent reasons to

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support his opinion. His article, too, is scheduled for September reading.

TODAY syphilis has become a popular issue. Even such organizations as the Lions' clubs are joining in the attack on this ancient enemy of man. Newspapers, which a few months ago abjured the word, now print columns about the nationwide campaign against it. Health departments all over the country are keyed up to lead the fight in city and state. Where do hospitals fit into this picture? Can they offer resources that will help to rid women of crippling, babies of blindness and men of insanity? The U. S. Public Health Service which, under the vigorous leadership of Dr. Thomas Parran, is stimulating and directing the campaign sees an important place for hospitals. Dr. R. A. Vonderlehr of the service will describe this place next month.

WHAT should the ideal small laboratory contain and how should it be arranged? Next month Dr. Laurence H. Mayers of Chicago will give his answers to these two questions by describing a compact and efficient small laboratory.

"IN NO building are windows more important than in the hospital," declares Mary B. Anderson, in an article on window washing to be published next month. She proceeds to give practical pointers on just how this may be done to the best advantage. Window washing costs, Mrs. Anderson reveals, vary from 5 cents in the spring to 8 or 10 cents in the summer with still higher figures in the winter.

ANOTHER excellent housekeeping article is scheduled for September, "The Golden Rule in Housekeeping" by Alice M. Eldridge of Fairmont Hospital, San Leandro, Calif. Mrs. Eldridge discusses the important points in personnel management that face the housekeeper and indicates correct procedures for each difficulty. In view of present labor unrest her article is timely. After you have read both of these articles, they should be especially called to the attention of your housekeeper. The same

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BREAD AND BUTTER BUSINESS

DAY after day, modern surgery, under safe anesthesia, concerns itself with the restoration to health of countless thousands of "ordinary" patients. Few of these patients realize how much a good anesthesia contributes to the success of the operation.

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SQUIBB ETHER

may be said, incidentally, of the good housekeeping material in this issue commencing on page 86.

FOUR years ago The MODERN HOSPITAL originated the idea of printing a month of menus in each issue. The first year, dinner menus for the general hospital patient were assembled, followed in the second year by breakfast and supper menus. The third and fourth years saw the same sequence in menus for the staff. The series has proved most valuable to dietitians.

Most of these menus, however, were prepared by dietitians from the larger hospitals. Commencing next month we shall present similar material prepared by dietitians in small institutions, whose problems are somewhat different. These dietitians have been asked to be perfectly honest in their menus and set down the kind of meals that they know are practical for small hospitals. The results should be useful to small hospitals everywhere. Large hospitals, too, will probably find many ingenious ideas.

FLASHES FROM THIS ISSUE:

"Hospital employees are obligated . . . to refrain from any joint action with other employees that will cause any interruption of any phase of the hospital's service and to do nothing whatever to jeopardize the safety, welfare and recovery of hospital patients." *Page 53.*

"The technician must keep in mind that he sees only half of the picture and that the clinical side of the picture, which he does not know at all, is still the more important half." *Page 62.*

"The skilled medical supervisor develops an aptness and ability in recognizing objective symptoms that may escape the untrained eye of the young doctor." *Page 75.*

"Hot sal soda is good for cleaning and deodorizing toilets and drain pipes and will cut your plumbing repair bill considerably with no damage to pipes or porcelain bowls." *Page 90.*

"If health services of large cities are to meet best their largest obligations they will have to adopt the administrative device of decentralization of field services through district or neighborhood offices." *Page 41.*

"Keeping of a daily food cost report is a game that can be played with as much interest as any game of contract bridge, if certain standards and methods are set up." *Page 92.*

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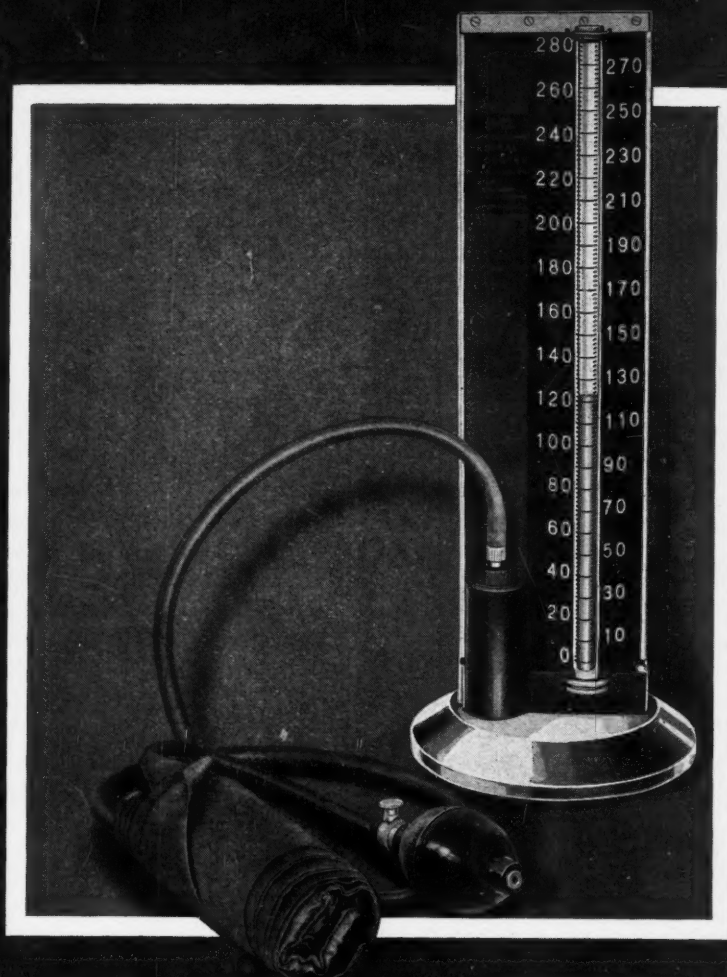
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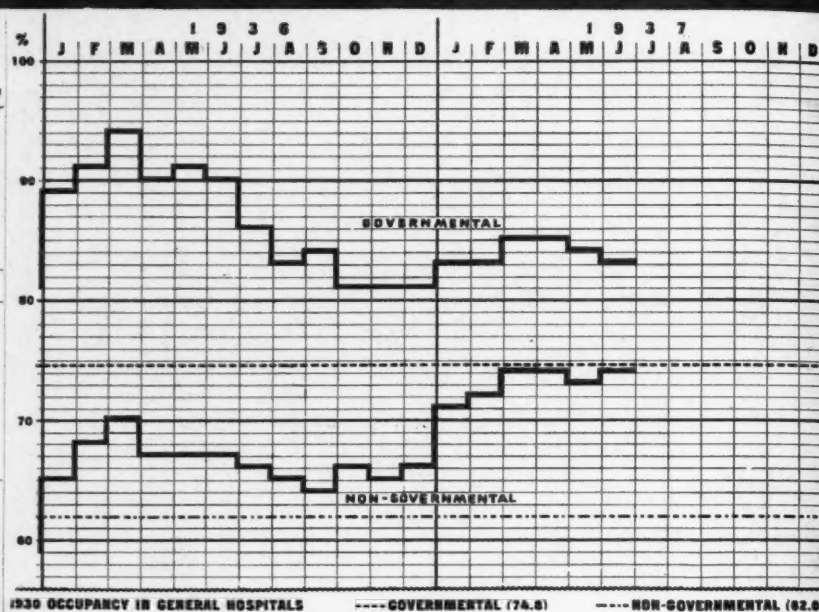
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HOSPITAL OCCUPANCY BAROMETER

| | Census Data, on Reporting Hospitals ¹ | | 1937 | | 1938 | |
|----------------------------------|--|-------------------|------|-----|------|-----|
| Type and Place | Hosp | Beds ² | June | May | June | May |
| Government | | | | | | |
| New York City..... | 17 | 11,328 | 99* | 99 | 90 | 100 |
| New Jersey..... | 5 | 2,122 | 89* | 89 | 82 | 84 |
| Washington D. C..... | 2 | 1,596 | 70* | 70* | 66 | 63 |
| N. and S. Carolina..... | 13 | 1,445 | 73 | 70 | 75 | 73 |
| New Orleans..... | 2 | 2,466 | 98* | 97 | 168 | 164 |
| San Francisco..... | 3 | 2,255 | 85 | 89 | 81 | 81 |
| St. Paul..... | 1 | 850 | 69 | 73 | 78 | 80 |
| Chicago..... | 1 | 3,419 | 84 | 86 | 84 | 85 |
| Total ⁴ | 44 | 25,481 | 83* | 84* | 90 | 91 |
| Nongovernment | | | | | | |
| New York City ³ | 68 | 15,194 | 81* | 81* | 73 | 76 |
| New Jersey..... | 50 | 9,772 | 71* | 71 | 64 | 66 |
| Washington, D. C..... | 9 | 1,793 | 77* | 77* | 73 | 71 |
| N. and S. Carolina..... | 103 | 6,663 | 70 | 68 | 67 | 65 |
| New Orleans..... | 7 | 1,146 | 69 | 69 | 63 | 59 |
| San Francisco..... | 15 | 3,129 | 75 | 77 | 73 | 71 |
| St. Paul..... | 7 | 800 | 74 | 76 | 59 | 61 |
| Chicago..... | 13 | 2,256 | 66 | 66 | 64 | 64 |
| Cleveland..... | 9 | 1,343 | 80 | 75 | 68 | 74 |
| Total ⁴ | 281 | 42,105 | 74* | 73* | 67 | 67 |

¹Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. ²Including bassinets, usually. ³General hospitals only. ⁴Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January, 1933, to October, 1936, are given on page 800 of the Fifteenth Hospital Yearbook.



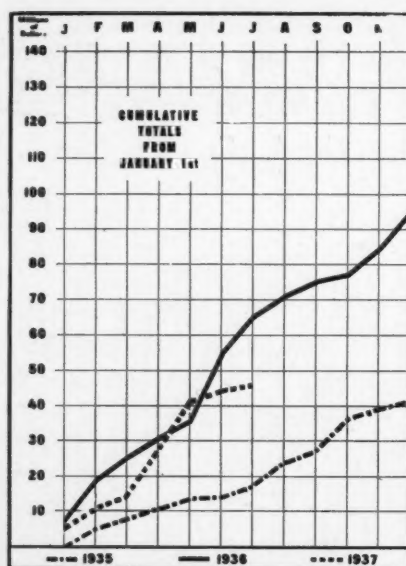
Consistent Rise in Occupancy for Five Years

Hospital economists will find much to interest them in the consistent rise of occupancy in nongovernment hospitals since 1933 as shown in the following table which gives the average percentage of occupancy in both government and nongovernment hospitals for the first six months of 1937 as against those for the same period in 1933, 1934, 1935 and 1936.

| NONGOVERNMENT | |
|---------------|--------------------------|
| Year | Occupancy (First 6 Mos.) |
| 1933 | 55 |
| 1934 | 58 |
| 1935 | 62 |
| 1936 | 67 |
| 1937 | 73 |
| GOVERNMENT | |
| 1933 | 86 |
| 1934 | 89 |
| 1935 | 89 |
| 1936 | 91 |
| 1937 | 84 |

It will be noted that while the business outlook as evidenced by increased occupancy in nongovernment hospitals grew steadily better, with an average of 55 per cent for the first six months of 1933 as the lowest ebb, the load in government hospitals also increased until 1936 when it hit 91 per cent and then fell off sharply in the first six

HOSPITAL CONSTRUCTION



months of 1937 to new low of 84 per cent.

The seasonal slump in construction continued into July with 28 new projects reported with total costs of \$2,524,561. Additions to existing buildings accounted for 17 of the 28 proj-

ects at a cost of \$1,521,061. Nine new institutions and one nurses' home were planned, the hospitals to cost \$978,500 and the nurses' home, \$25,000.

General wholesale prices reported in the index of the *New York Journal of Commerce* jumped from 89.9 on June 21 to 92.3 on July 12 and then dropped off a little during the following week. Grain prices, after dropping sharply to 108.1 the end of June, began a steady climb during July to reach 114.8 on the seventeenth. Food prices rose 3.8 points in one week and continued to soar until they reached the highest point in several months—88.2. Textiles and fuel have see-sawed back and forth a few points, textiles dropping off a trifle to 74.0 and fuel rising to 88.1. Building material prices continued to fall off to 103.0 the week of July 12 to 17. (All indexes based on 1927-29 as 100.) The price index of drugs and fine chemicals in the *Oil, Paint and Drug Reporter* rose only one-tenth of a point to 181.6 for two weeks and dropped back to 181.5, the place it has held for several months.

According to a National Industrial Conference Board release, unemployment in the United States declined between April and May by more than 600,000 persons to a total in the latter month of 6,246,000.

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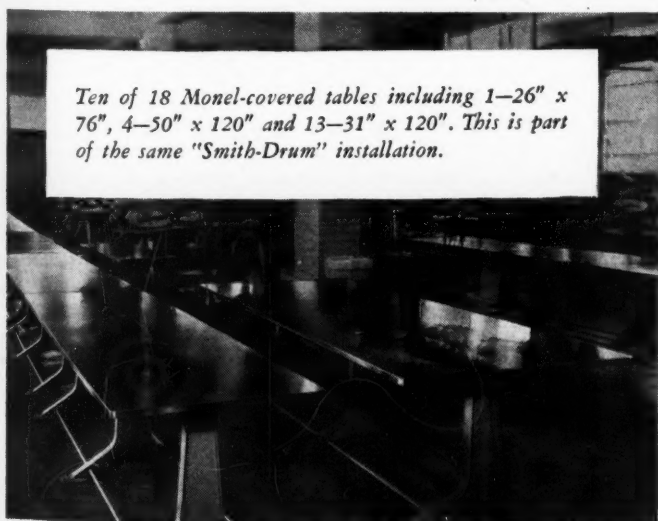
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The Editor Talks It Over

Sticking to Its Last

- It is said that John Hunter, the great Scottish physician and physiologist, once was engaged in searching for new anatomic secrets by the dissection of a human body, when a call came asking for his presence at the bedside of a sick man. Throwing down his instruments in disgust he exclaimed, "Now I must go and earn that d— guinea."

Research and general or even specialty practice do not go well together. The minds and interests of physicians engaged in these pursuits are formed in vastly different molds. And so it is when staff men propose the expenditure of hospital funds for research purpose. Before approval is granted careful thought should be given to the nature of the problem and particularly to the temperamental, scientific and leisure qualifications of the would-be investigator. It is possible that the average hospital should stick to its last of caring for the sick and leave expensive research to others better qualified in men and money.

More Taffy

- Boards of trustees should recognize a staff physician who has performed a creditable piece of clinical research or has had a case report accepted by a leading medical journal. A letter from the president or a report at the annual meeting often serves to stimulate a staff to better and more scientific institutional work. To publish from time to time reprints of articles published by staff physicians is a splendid policy. More taffy and less "epitaphy" is said to be a good administrative principle.

Unprofitable Side Lines

- Doctors as well as hospitals seem to have turned the economic corner. Each is manifesting less fear of the future. It is regrettable that the spec-

ter of economic dependence often confronts the physician and dwarfs or interrupts his scientific advancement. Dr. Benjamin Rush advised all young doctors to become farmers that they might be independent of the anticipated incomes from practices. Some hospitals develop side lines with no intention of so doing. Those that held many mortgages now own too many properties that they must rent and maintain in repair. The average hospital organization is about as capable of conducting a real estate business as was the early colonial doctor of both farming and practicing medicine.

Autopsy Etiquette

- The complaint of undertakers is not always unjustified. It would do hospital superintendents good to visit postmortem rooms occasionally while an autopsy is in progress. They would learn much by inspecting the results of tissue incision before a body is delivered to the undertaker. On the wall of each autopsy room should be posted a description of the incisions permitted and strict adherence to this rule should be required. The technique of suturing and of repairing external wounds should be almost as precise as that of the surgeon. Surely autopsy percentages cannot remain high if undertakers are to be ignored and if the esthetic in the preparation of the body is to be overlooked.

Kitchen Philosophers

- "Never punish a thinker," for there are philosophers in the hospital kitchen and the engine room as well as among the medical staff. Each worker may be trying to do a better and more efficient job; to him his work is the most important in the hospital world. He may be temperamental, since not only musicians display prima donna dispositions. The executive, like the manager of a baseball team, must

build his personnel machine of the materials at hand, understanding, cajolery, commands and compliments but rarely ridicule. Often when the angry waters of personalities begin to surge he is hard pressed to secure sufficient oil of tact to quiet them.

Ambulance Wisdom

- The economy of the new "cabulance" (a recently coined term and service), which can be rented at taxicab rates; the use of the ambulance of the local undertaker at a reasonable fee, and the moral obligation of the hospital to provide safe and comfortable transportation to the hospital without regard to cost, were pointed out by individuals at a recent state association round table.

All agreed that the hospital must not adopt the attitude of exhibiting a readiness to care for the sick and injured only when they are placed in the institutional receiving ward, as the hospital's responsibility for the physical welfare of a community extends into every home and every workshop. Often the wisdom of maintaining an ambulance service must be decided on the basis of need rather than cost.

Zippered Abdomen

- The "zipper" has great possibilities. Again it has been brought to the aid of science. Some surgeons and roentgenologists are proposing the direct treatment of malignancies of the abdominal cavity by x-ray with the abdominal wound open. Surely it stands to reason that such treatment would be more effective than that which endeavors a few days following operation to puncture by x-ray thick abdominal walls and the tissues of intervening abdominal organs. The placing of a zipper so that the abdominal wound can be opened on several occasions following operations and malignant growths in the peritoneal cavity treated by x-ray has its possibilities.

Looking Forward

Conference, Not Violence

"**A**NYTHING is good enough for the nonprofessional help." This attitude, whether conscious or unconscious, has prevailed in the thinking of far too many hospital administrators and boards. It has resulted, many times, in low pay, long hours, crowded and unattractive living conditions, food lacking in appetite appeal, or dictatorial treatment of complaints.

Today employees will no longer tolerate such conditions. They are infected with the contagion of employee rights, industrial democracy and group action. They know other jobs are available. Why not acknowledge frankly the fact that employees may and probably do have grievances and set up adequate machinery for dealing with them? It is common practice to have a conference committee to discuss medical staff problems. Why not similar conference committees for nurses and other professional employees and for the nonprofessional group?

Such a suggestion is not put forward as a panacea. No single act or policy is a panacea for all personnel problems. Even with such a committee, employees may join labor unions. But whether they do or not, a properly organized and functioning conference committee should keep the administration and the trustees aware of employee points of view and assist in ironing out difficulties before they become too great.

Program "Deadlines"

TO ENTICE the wary hospital trustee from his natural habitat into hospital association meetings constitutes a *tour de force* demanding all the diplomacy and persuasive powers of the skilled administrator. The more credit, therefore, to those who on occasion have proudly led a group of uncertain but willing laymen to front seats where they might be seen by all and duly admired. In devoting an afternoon of its meet-

ing exclusively to trustee problems the American Hospital Association has over a period of years sought the cooperation of its members in educating hospital trustees in the duties of stewardship. Surely a step in the right direction! And if the results have not been all that could be hoped for, they at least established a precedent on which to build.

How disheartening, therefore, to those administrators mindful of the need of such educational emphasis in these changing times to find their last trustees' meeting over and their boards disbanded for the summer with no definite word from headquarters on the program scheduled for Atlantic City. Some of these boards will not convene before the big show starts. When meetings do take place inadequate time remains in which to urge participation and ensure a representative attendance.

Publishing procedure demands the establishment and close adherence to "deadlines." The same rule observed by those responsible for program arrangements for national and state meetings would prove equally efficacious.

Hospital Care for Relief Cases

ALL hospital people will remember that during the worst years of the depression, when the financial needs of millions of families and thousands of hospitals were at their greatest, no bit of the federal funds that were poured out for "relief" were allowed to be used for hospital service. It is, therefore, noteworthy that a high official of the federal administration now declares publicly that hospital care should be part of a permanent medical-care program for the poor, which should be operated by localities and states, but to which federal funds should contribute on a grant-in-aid basis.

At the recent annual session of the National Conference of Social Work in Indianapolis, Josephine C. Brown, administrative assistant to

Harry L. Hopkins, reviewed the whole history of medical care under the Federal Emergency Relief Administration from 1933 to 1936, analyzed the problems that have arisen since the federal government withdrew from direct relief and concluded her address with these significant recommendations:

The immediate need of a definite and adequate program for medical care is intensified by recent developments in public welfare, and by the fact that a number of state legislatures have already made some statutory provision to this end. . . . A permanent program of medical care should serve not only the families who are recipients of those federal benefits, (*e.g.* old-age assistance; work-relief) but also the hundreds of thousands of families receiving state and local general relief. But over and above these groups, I believe that eligibility should be open to all families whose income does not provide the minimum cost of adequate medical care in addition to a reasonable subsistence compatible with decency and health.

Dr. Thomas Parran, surgeon general, and president of the American Public Health Association, made the following statement in his presidential address in New Orleans last October:

"In principle I hold the view that all community services for the prevention of disease and care of the sick should be the responsibility of the health department, insofar as such measures are paid for from public funds. The extent to which these services are actually administered by the health department, however, is a matter that can best be decided by the individual state or locality."

Profiting by the experience of the FERA medical relief program and fortified by Doctor Parran's statement, I, as a layman, venture to make the following recommendation:

That a permanent medical care program can best be provided through the extension of the responsibilities of local public health units, under the supervision of state departments of health, to include diagnosis and treatment; medical, surgical and dental, accompanying nursing care and medical social service to persons who cannot afford to pay private physicians, and hospitals. This care should be provided as needed in clinics, hospitals, sanatoriums and through home visits, and should include chronic as well as acute illnesses. The program should be flexible and readily adapted to local conditions. . . . The most advantageous development of such a program would be secured by a federal appropriation to the U. S. Public Health Service for grants in aid to the state departments of health. These funds should be combined with state and local appropriations, using either a matching or equalization plan, depending upon the local situation. The program should be considered one of medical service, not relief, and should be an integral part of the social security provisions of the federal government.

Miss Brown's proposal is similar in principle to the program of care for the "medically indigent," proposed in June to the American Medical Association in a set of official resolutions of the New York State Medical Society. This plan was, in turn, based upon the suggestions of the distinguished body of physicians who sponsored the report of the American Foundation summarized in the May MODERN HOSPITAL. Whether

departments of health or departments of public welfare serve as the administrative agents in the states and localities is, as Doctor Parran suggests, a matter for local determination. Are government, medical profession and hospitals now coming to agreement upon a common objective? If so, perhaps all the benefits of a far-reaching program can be realized and its possible disadvantages be avoided.

Nurses Needed

STRIKING evidence of the shortage of nurses was offered last month in New York City. The Department of Hospitals on July 1 adopted a straight eight-hour day for all employees, except administrative officials, physicians and superintendents of nurses. To do so required \$1,500,000 more for pay roll and 2,793 additional employees, including 1,281 graduate nurses.

To recruit such a body of nurses, the department turned to the WPA, the National Reemployment Service and the state employment service; it wrote letters to 1,400 schools of nursing and placed advertisements in all available professional magazines and in twenty-five leading newspapers. Meetings of district nurses' associations were addressed by spokesmen for the department and each superintendent of nurses made efforts in her own locality to obtain nurses. High school and vocational schools also helped. Finally cooperation was offered and accepted from District No. 13 of the Association of Hospital and Medical Professionals and from nursing organizations and relief agencies.

Up to June 25 the department had actually employed 320 nurses and had had inquiries from 1,582. Apparently some of these nurses are resigning from the voluntary hospitals to go into city employment. To have received so few applications from so comprehensive an effort must indicate that unemployment among nurses has practically disappeared.

Now, in order to retain their nursing staffs, the voluntary hospitals in the New York area must also adopt the eight-hour day if they have not already done so. This will create a further demand for nurses, which will doubtless be felt throughout the entire Eastern half of the United States. California and other Western states have been drawing nurses from the Middle West for several months.

The eight-hour day and 48-hour week are, beyond doubt, constructive steps toward better care of patients and better treatment of nurses and other employees. With industry rapidly adopting a 35 to 40-hour week, hospitals cannot ex-

pect to work their employees for 52, 56, 60 or more hours.

The immediate and pressing problem is to obtain enough money and enough personnel to meet the new situation. Fortunately the public has already demonstrated that it will now respond to requests for funds. Intelligent publicity, especially if undertaken jointly by all hospitals of the community, can also "sell" the public on the necessity of higher rates to meet higher pay roll costs.

Coupled with the increased pay roll must be an expansion of the good nursing schools. True, the use of attendants will help somewhat but they cannot and should not supplant the fully trained graduate nurse. Hospitals with adequate funds, teaching personnel and patient census should increase their classes, not by lowering the quality of entrants but by telling promising girls of the opportunities now to be found in the nursing profession.

The A. M. A. Resolves

AT THE convention of the American Medical Association held in Atlantic City in June the following resolution was offered: "*Resolved*, that the employment of nurses, technicians and lay individuals, except those registered in the active pursuit of a medical degree, as anesthetists, is basically illegal, unethical and should not be tolerated in the best interests of the patient."

Such an action should be given mature thought before adoption as the opinion of a great medical association. High court opinions are available as to the legal angles involved in the administration of anesthetics by nurses. It has been repeatedly stated that the surgeon is responsible for the acts of his agents and that if he designates a trained nurse to administer an anesthetic by inhalation or a narcotic by hypodermic he in the end is responsible for the results.

Few would hesitate to choose a well trained medical specialist instead of a nurse no matter how well trained to administer an anesthetic. Yet most physicians have not cared to give sufficient time to become experts in anesthesia and many nurses have done so.

The medical association can do much toward protecting the welfare of the surgically ill if it will stress the necessity of establishing courses in anesthesia for doctors and of deprecating the fact that a medical degree guarantees that its possessor is a specialist in anesthesia.

Some physicians have found this an interesting and well-paying specialty. Most doctors, however, look upon it as a practice which is of

side line proportion and which does not require serious study in order to become expert. There are many highly trained and highly efficient nurse anesthetists. Before these are declared illegal the medical profession should furnish well trained physicians to take their places. It is well that the resolution in this form did not pass.

Ruthless Competition

IN PRESENTING the report on the hospital survey for New York recently, Dr. Haven Emerson, director of study, made some remarks that are as applicable to many other communities as they are to the New York metropolitan area. Doctor Emerson said in part:

"The development of the more than 800 institutions and agencies has been haphazard, individual, premature in one instance or unduly postponed in another. Each building, group of new personnel, specialization of structure, equipment or direction of effort has been apparently to meet an emergency, never to forestall one. There have been no predetermined plans worked out with reasonable consideration of the ambitions and potentialities of others already on the scene. There has been nothing more ruthless in industry and commerce, more reckless of social morality, more rugged in its autocratic autonomy than the conduct of campaigns of individual institutions for this, that or the other utility for the sick.

"No one familiar with local history for the last thirty years will deny that there has been and continues to be waste in capital expenditure, overbuilding and under-use, under-cutting and overselling in the field of the institutional care of the sick. The remedy seems to us to be the development of a permanent, representative, authoritative planning group so informed and made currently aware of the facts of each situation, and so independent of class, institutional or political loyalties that its judgment in all projects involving capital expenditures will be sought, accepted and respected. There are the men and women equipped for such a voluntary public service. . . .

"Voluntary control and coordination of the sprawling accidental agglomeration of existing hospitals and similar agencies are indispensable. We shall never be rich enough to repeat the mistakes of the past. As we approach a more nearly stable population, the more practicable does it appear to develop services for the sick on the basis of accurate estimates of calculable needs."

To all of which we must give assent.

City Health Center

THE district health center is as inevitable as the district fire house, school or police station. It is now almost twenty-five years old in the United States. As a piece of administrative machinery it plays a double rôle. It is a substation of the city health department, from which field agents carry services to the homes of the district, and to which all necessary information of persons and families and premises of the district is brought or sent—a neighborhood office in the citywide organization of civil government. It is also a meeting point in which official and nonofficial agencies can readily collaborate for common purposes.

As expressed in the Encyclopedia of Social Sciences, "This new unit in city neighborhoods and in rural county seats or crossroads, the health center, is a fitting physical and functional expression of an ideal based upon the recognition of the need of continuous central coordinated health work for local population groups. The health center may be likened to the chain store, where the resources of the earlier general department store are brought conveniently close to many small neighborhoods and communities."

Disagreement on Function

There are other ideas commonly held regarding the function of the health center which call for consideration, and particularly two: (a) some would make a health center into headquarters for all variety of out-patients and even for emergency or temporary bed care of the sick, in other words, a branch of the hospital facilities of the community for diagnosis and treatment of disease; (b) some would provide in the health center for official and nonofficial welfare agencies, for relief visitors and district relief administration and for visiting nurse associations.

Before discussing the former conception of this new intriguing instrument for social ends, let us define the two public applications of medicine: organized care of the sick and the public health service.

Organized care of the sick is the diagnosis and treatment of disease through institutions and agencies. Its eight functions are: hospital, dispensary, convalescent home, chronic home, visiting

nurse service, medical social service, ambulance service and home medical care.

Public health service is the application of the medical sciences by government for the prevention of disease for social ends. Its six functions are equally well defined: vital statistics, communicable disease control, sanitary control, laboratory services, maternity services and child hygiene, public health education.

Here are fourteen specialized activities. You must decide whether this new instrument you are going to create is to undertake one or the other of these groups of functions. My own opinion is that only services for health provided by the health department should be administered through the health center.

I do not believe that the diagnosis and care of the sick should be undertaken in a city health center, even in the fields of tuberculosis, syphilis, gonorrhea or maternity or for the administration of immunization procedures, except under temporary or emergency conditions.

A health center may, as in Alameda, Calif., be operated adjacent to or actually as a part of a public hospital and out-patient dispensary. There are certain advantages in having a health center located in the immediate vicinity of well developed organized medical services for diagnosis and treatment of disease and there are possibilities of co-operative use of records, personnel and other facilities. As an example, the visiting or public health nurse may serve both the medical treatment institution and the health center, but the two activities are best carried out under separate directions.

Now for the second conception of a district health center. In New York and Boston the district offices give free space to private agencies dealing with the whole family problem. Although there is real convenience in agencies dealing with the whole family problem having access conveniently to records and competent report systems in the health center building, I am not favorable to government subsidizing of private agencies. Housing such agencies, rent free, is subsidizing.

By HAVEN EMERSON, M.D.

*Only services for health provided by the health department
should be administered through a city health center.
Diagnosis and care of the sick should not be undertaken*

There is no more propriety in expecting taxpayers to provide district offices for philanthropic agencies engaged in social relief purposes than there is for police stations to have offices for legal aid or crime prevention agencies, or for recreation leagues and the W. C. T. U. to have space and maintenance provided in the public schools.

Stripped of complexity and controversy, the health center in a large city should be now, as in its origin, the district depot for all field services of the health department and should be under the exclusive control of the district health officer. In a well developed line and staff organization it is the distributing and collecting office for all field activities in the appropriate district.

If health services of large cities are to meet best their largest obligations they will have to adopt the administrative device of decentralization of field services through district or neighborhood offices. They can do this without sacrificing the benefits of a central staff organization to provide the direction, planning, standards, analyses of records, laboratory, epidemiologic and statistical services indispensable for any city health department.

It seems to me that only by creating an economical district unit for the conduct of official neighborhood health work will the health center be able to justify itself.

Government should take primary responsibility for all public health activities as previously defined and more and more this duty is recognized by the appointment of a more trustworthy type of health officer, by better security in office and through the use of less inadequate appropriations. When for social, political or financial reasons the performance of the local government, aided or not by state grants or federal subsidies, lags behind the conscious needs of the community, volunteer health activities and the aid of philanthropy can usually be found to develop supplementary services.

Whether health work is wholly tax supported, as is rarely the case in the United States, or is largely provided by volunteer health agencies, as is common in both cities and rural areas, the administrative device of the center offers the best prospect

of satisfying a community or neighborhood social consciousness of its health needs, with least waste of time, money and energy and with the greatest tangible results through education and example.

Essential to the success of any health service by government is close collaboration with the six professional groups to be found in almost every city neighborhood: doctors, visiting nurses, dentists, school teachers, the clergy, and social workers, also with the local press, labor, real estate, merchants and manufacturing interests, and parent-teacher organizations, all of which groups should be welcomed to use the assembly or lecture rooms of the health center for public purposes in the interest of neighborhood health.

No Deciding Voice

These groups should be consulted, but they should not have a deciding voice in the function and operation of the health center. The New York system has set up two advisory groups—one of doctors and one of the health agency group. They are in a position to dominate the policies and activities of the health officer although they have no official responsibility. I think you will come to believe that these groups sitting in with the health officer should not have a deciding voice as to policies, records or functions. They should however, confer with the district health officer and through the district health center, take advantage of opportunities for coordinated and cooperative service.

What part should the health commissioner play in this? My feeling is that until the health commissioner has taken the thing, hook, line and sinker, and is whole heartedly committed to the project there is no use for the private agencies bothering themselves with the matter at all. Until the health commissioner has pledged himself to support and back the health center as a pleader before the appropriating body of the city there is no use of private philanthropy getting into it. We must be committed to a government body undertaking this as a project to improve its services.*

*From an address presented before the annual meeting of the health division, Chicago Council of Social Agencies, June, 1937.

This Way to the

By RAYMOND P. SLOAN

WHERE would the big show be without its side shows? Ask the barker what it takes to attract an audience. Ask the spectator if, despite all the ballyhoo, these added attractions do not in themselves make a big show.

You have the answers, my friends. Be sure you don't forget them, your ticket, too, as you embark on your journey to Atlantic City, that greatest of all American seashore resorts, the playground of the world, ladies and gentlemen, where in the most spacious, pretentious and luxurious of all public auditoriums you will witness the most colossal, complete and costly collection of contrivances designed wholly for hospital convenience ever assembled under one roof! Welcome, ladies and gentlemen, and whomever you may bring with you to the thirty-ninth exhibit of the American Hospital Association.

How your tickets read and what stopovers you have arranged are beyond the ken of your scribe, but he will assume, nevertheless, that few of you either going or coming will not permit yourselves a few hours or days in New York City. Also that while in the big city some of you at least will want to look around a bit—at hospitals, that is. Any number of reliable amusement guides will supply the rest.

What was that? Did someone say "Medical Center"? Of course they did. They always do when New York is mentioned. Take either one you wish. If you hesitate because of showing preference, choose a river, Hudson or East. You can't go wrong—the Columbia-Presbyterian Medical Center is on the banks of the Hudson and New York-Cornell has the East River lapping at its side.

You see you are on Manhattan Island, bounded on the west by—. Perhaps we can step out of character just long enough to suggest that if you



Three full stops here! Roof solariums for tuberculous patients, Jersey City Medical Center (top); solarium at Harkness Pavilion for Private Patients, Presbyterian, New York (center); Jewish Hospital, Philadelphia (bottom).

Side Shows

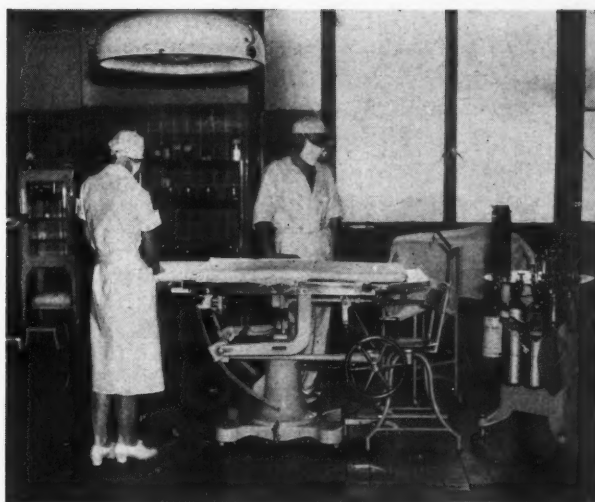
Some Stopovers on the Way to Atlantic City

really want to get the lay of the land, you can do no better than to take one of those little boats that make the trip around the entire island. The excursion requires but two or three hours and is a thrilling experience, particularly on a crisp fall afternoon when the skyline is sharp and clear. If your amusement guide fails to supply full information, call Ashland 4-2445. Yes, The MODERN HOSPITAL, of course.

If you would a-medical-centering go, make up your minds at the start that you can only hope to see a small fraction of all there is to see, unless you prolong your stay into weeks or months. Wiser, therefore, to select that phase of your work which is nearest and dearest to your heart, and concentrate.

The "eyes" have it at Presbyterian. That is to say you will find there one of the most modern and perfectly equipped buildings for eye surgery anywhere in the world. It alone is worth a trip to 168th Street. But any other department is likely to prove equally interesting and stimulating. Ask to see the solarium on the top of the Harkness private pavilion and some of the rooms that have lately been furnished. If you don't come away with all sorts of ideas for interior decoration, it will be surprising. The entire group is recommended as an outstanding example of efficiency and sound organization as applied to large hospital procedure.

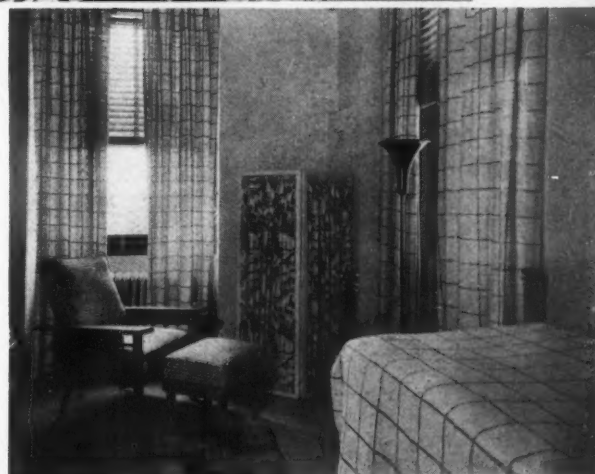
Assuming that you may be interested in checking on maternity service as practiced in the metropolis, you would do well to start with the Lying-In Hospital, which is a part of New York Hospital. No radical departure from usual routine here, but merely a generally efficient set-up. If you have ever given any thought to installing cafeteria service in your hospital, make it a point to introduce yourself to Margaret Gillam, dietitian, and gather first-hand information on all details. And



Surgery at new Queens General; room at Hospital for Joint Diseases.



Deck scene on roof of Polyclinic; another room at Hospital for Joint Diseases.



another suggestion for your notebook! Spend a while in the engineering department. Sorry that space doesn't permit more details. But you will find your time well invested, that we'll guarantee.

How many of you are handicapped with old buildings that need almost everything done to make them even half as efficient as they should be? For this group we would suggest some time spent in Mount Sinai Hospital, which is easily reached by Fifth Avenue bus. Climb up on top where you get a better view and don't hesitate to ask questions of your neighbor. Provided he, too, is not a visitor, he will be glad to point out to you where all those who used to be millionaires live facing Central Park. That building on your left when you pass Eighty-Second Street is the Metropolitan Museum.

Some Feats of Modernization

While you are excursioning up to 100th Street, rubbernecking the while, you should know that last year Mount Sinai finished modernizing two thirty-five-year-old buildings. Possibly you read all about it in the September, 1936, issue of *The MODERN HOSPITAL*. The entire job took a year. If you insist on figures, the total cost was \$225,000. Some 1,938,500 cubic feet of construction was involved, the renovation cost being 11.5 cents per cubic foot. Two other "musts" at this stop. Get Dr. Joseph Turner, medical director, or John B. Cubberley, head of the engineering staff, to show you the portable linen closets or trucks. They were planned and executed in the hospital's own shops. And speaking of shops, don't miss the Mount Sinai maintenance department. The second "must" is Adeline Wood's charts on food purchasing, especially meats. Her office is in the basement to the left as you walk down the stairs.

Hold on a minute before ending your notes on modernization. Not so long ago Lenox Hill Hospital on Park Avenue at 76th Street also played all sorts of tricks on an old building. For further details refer to *The MODERN HOSPITAL* of March, 1935. John Hayes will be glad to point out the modern miracles performed.

One thing leads to another. Would you like ideas on how a nurses' residence can be transformed into a modern maternity pavilion? Take pencil in hand then, and jot down the name of the French Hospital. It's on the west side of the city on 30th Street.

Now get ready for a jaunt downtown. By all means take the elevated instead of the subway. You see so much more. What a contrast this excursion down the East Side via the Second Avenue "L" to Beekman Street Hospital from that ride up Fifth Avenue to Mount Sinai. As you swing

around treacherous looking curves, which after all are quite harmless, you gaze into tenement rooms and ten-cent lodging houses. Beneath you the streets are lined with vendors' carts pulled up along the curb, each merchant trying to outdo the other in the bargains offered. Believe it or not, you are still in New York, a city composed of many little cities.

The little city for which we are bound lies in the shadows of the famous Brooklyn Bridge. Take a look at this old span while you're in the neighborhood. It was the first of several that now link New York with Brooklyn and Long Island.

Beekman Street Hospital may be disappointing at first glance, but what an interesting background it has and a reputation second to none for accident and fracture therapy. In a sense it is a community hospital, serving a community comprising some thirty city blocks and possessing a daytime population of nearly a million, and a resident population of about 40,000. If you want to get some ideas on emergency fracture treatment, take a ride in one of the hospital's ambulances. You will find one always waiting at the front entrance.

Having finished with Beekman Street we'll return uptown still sticking to the East River. Time will permit only the most cursory glance at Bellevue, but surely a trip to New York would not be complete without at least a visit to this historic institution which was founded in 1736 and has been expanding and developing ever since. Today under the direction of Dr. S. S. Goldwater, commissioner of hospitals, it provides 2,400 beds for the indigent sick, treats 65,000 bed patients and 600,000 clinic patients yearly.

You'll find it overcrowded, to be sure, with beds stuck here, there and almost everywhere, but a new \$3,000,000 pavilion in course of construction will help some. That will be a sight for your next visit. This time take a look at the new acute tuberculosis wards which accommodate 350, also at the psychiatric unit comprising 600 beds. You will find enough here to make your visit thoroughly worth while.

Looking Down on a Rising Group

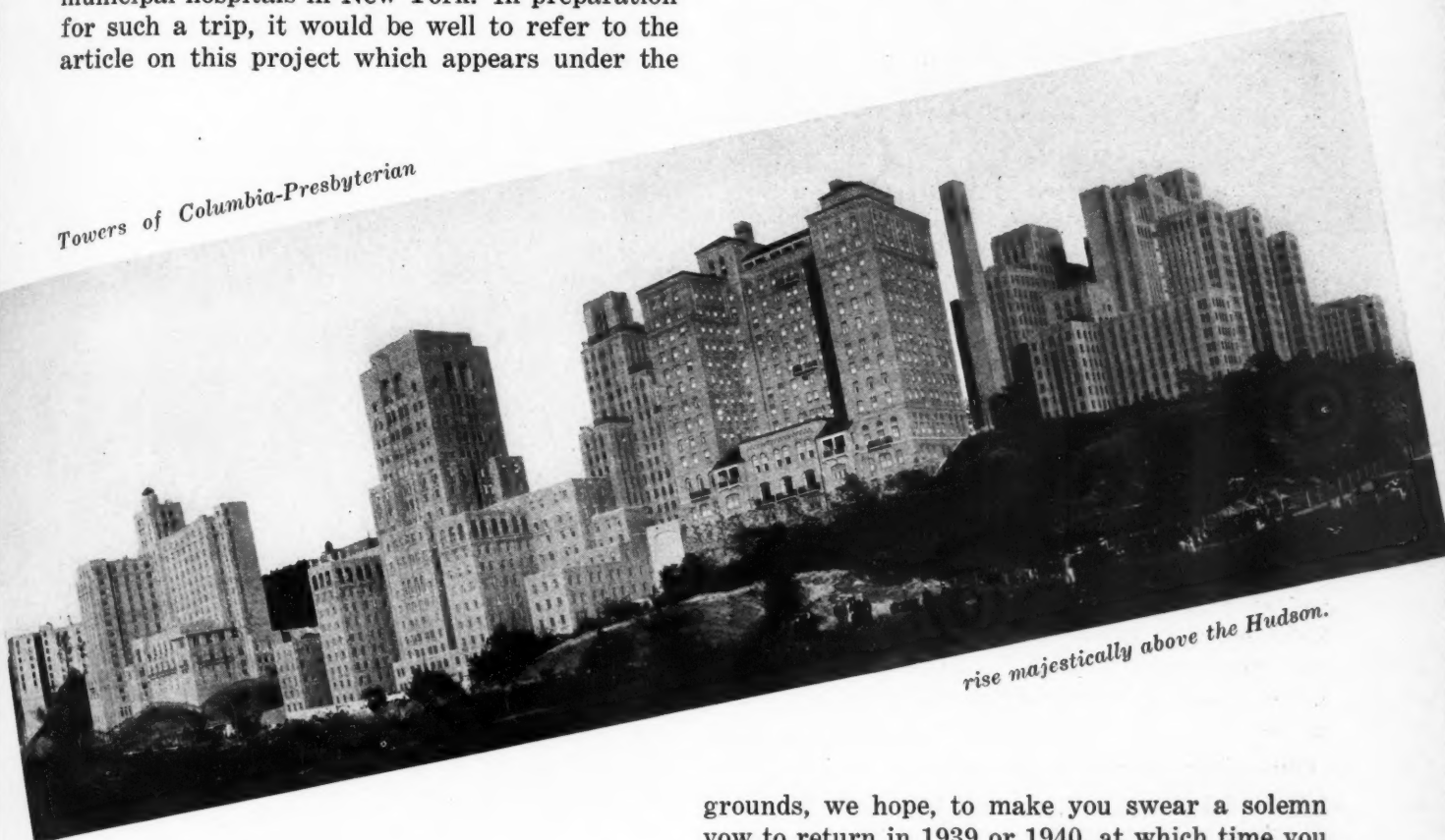
Now for another of New York's outstanding sights. This might be included on a day's outing to Long Island, for if you travel by motor over the Queensboro Bridge, which leads from Fifty-Ninth Street to Long Island City, you pass right over Welfare Island. The less said about the island's past, the better. What concerns everybody most, and particularly Doctor Goldwater, is its future.

Those great steel wings you see stretching out in all directions comprise the framework of the new 1,500-bed hospital for chronic diseases to be

known as Welfare Hospital. The island was previously shared by the department of hospitals and the department of correction. The old buildings have been razed and the entire island will eventually be hospital territory. Unfortunately, it is impossible to gain much of an idea of the significance of the enterprise at this stage in its development but, time permitting, a walk about the island, which Doctor Goldwater's department will be glad to arrange, will furnish some idea of this construction program for the development of municipal hospitals in New York. In preparation for such a trip, it would be well to refer to the article on this project which appears under the

Now let us continue our trip across the Queensboro Bridge. This excursion is selective, not compulsory. It includes a preview of the New York exposition of 1939, which is gradually assuming definite shape on the Flushing meadows, also a brief look about the new Queens General Hospital. There is nothing specific to which attention should be directed in this institution, but its name appears rightfully on the recommended list as an unusually efficient unit for service of its type. You will have seen enough of the exposition

Towers of Columbia-Presbyterian



rise majestically above the Hudson.

title "The Fruit of Research" in the March, 1937, issue of *The MODERN HOSPITAL*. The nurses' home is nearing completion but the hospital itself will not be ready for occupancy for another year and a half.

Before continuing the trip over to Long Island, an additional note should be made in your memoranda on chronic disease facilities in New York. You don't have to wait a year and a half to see the treatment of chronic disease patients become a reality.

There is the Montefiore Hospital which for years has enjoyed a unique reputation for such service. It can be reached most quickly by the East Side subway, and time, of course, is a factor in covering such distances as are necessary when "doing" New York. Montefiore is located at Gun Hill Road and Bainbridge Avenue.

grounds, we hope, to make you swear a solemn vow to return in 1939 or 1940, at which time you will want to go further afield on Long Island and inspect some interesting small community hospitals, several large mental institutions, and an unusually attractive county tuberculosis hospital. By the way, put that down now. It's the Nassau County Sanatorium, and the town is Farmingdale.

Better retrace our steps now across the bridge and into the heart of New York. Most of our pilgrimaging has been along the East Side of the city, so now we'll aim directly west, working down from the Presbyterian Medical Center, whose great walls and towers loom imposingly on the banks of the Hudson.

Hospitals with a view of the river possess all sorts of potentialities in their roofs. Several of them, too, have taken full advantage of them. So don't despair because the town's "hot spots" have moved from the roof to the basement before your arrival. Hospital roofs will give you a good show



Sick bay to the left. Light and shadows accentuate the modern lines of Philadelphia's new Naval Hospital, which provides 650 beds for officers and enlisted men. It is a PWA structure. Below is the semi-private pavilion at Mount Sinai, Fifth Avenue at 100th, New York City.

if September weather in New York lives up to its reputation.

Let's take the elevator for a minute up to the roof of Polyclinic, to inspect a veritable marine scene, with deck chairs, steamer rugs, even life savers and what looks like an honest-to-goodness sailor in attendance. Never mind, the uniform makes the man. So this is hospital life in New York!

A second stop must be made in this hospital to look over the new building that has only lately been equipped for clinical service. Do you recall the description of the new x-ray department which appeared in the July issue of *The MODERN HOSPITAL*? Check this against your own personal impressions as you walk through, and see if it contains a single word of exaggeration. Quite the finest layout of its kind, anywhere, you'll agree, we feel sure. Also while in the building, ask Mr. Jaller, or Mr. Pearson, to show you the eye clinic. It won't take a moment, and you'll feel repaid.

No complaints about tired feet, or aching muscles, if you please, until we finish with St. Vincent's Hospital, which is down by Twelfth Street on the West Side. Sister Stephen will probably apologize for the private patient pavilion, but it has an atmosphere that many a brand new building misses. One of these days it will be replaced.

The clinics are what we want you to see, and what clinics! All day patients stream in and out—the poor underprivileged from tenements in this congested downtown district. Let us hope you will strike an afternoon when the well-baby's clinic is in progress. The hospital actually gives prizes to the healthiest babies.

You have been extremely patient and are entitled to a brief respite during which we can



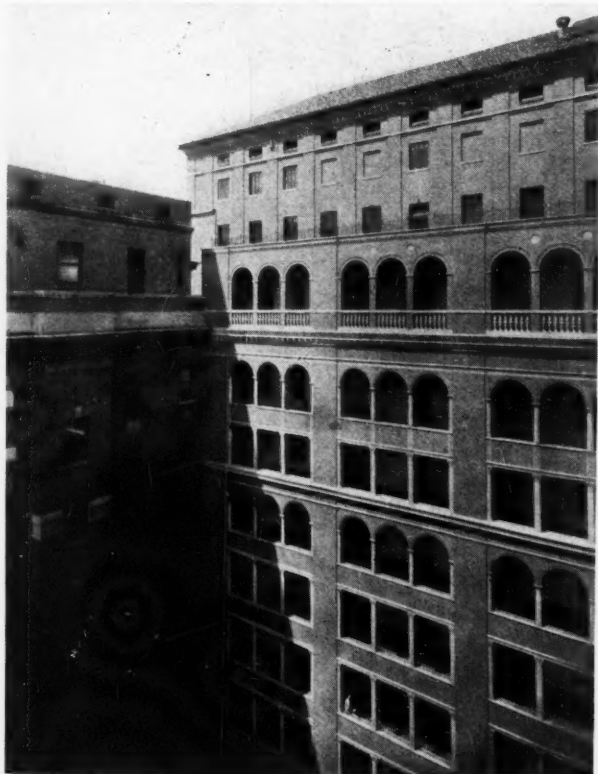
discuss your plans for the week-end, either before or after the big show at Atlantic City. You will be assured no warmer welcome anywhere than at St. John's Riverside Hospital at Yonkers, N. Y., just half an hour from the center of New York City. We hear more and more about personality in hospitals. After a few hours spent with Captain Warfield and a walk through St. John's Riverside, you will have a clear idea of what it means. Everywhere you turn are ingenious ideas that you will want to jot down for future reference. Above all else, don't miss the roof garden, which also has a distinctly marine air about it, and the dietary department. What other kitchen can boast a silver star on its ceiling! Then, there is the children's department and play terrace.

Is convalescent care much on your minds? If not, it should be, for there has been altogether too little emphasis on this phase of health work.

There could be no better opportunity for studying what is being done in this direction around New York, than over a week-end. On a beautiful country estate of many acres at Eastview, N. Y., you will find Mrs. Rachel Israel an enthusiastic hostess at the Solomon and Betty Loeb Memorial Home for Convalescents. Then there is the St. Luke's Convalescent Hospital at Portchester and the Burke Foundation for Convalescents at White Plains, which boasts a physical plant second to none.

En route to and from Atlantic City there are numerous points of interest such as the Jersey City Medical Center. You will want to see everything here, but it just can't be done in the time allowed. Put first on your list, therefore, the maternity department and be sure to have your notebook handy.

East Orange, N. J., is practically on the route, if you are driving. You have already heard about Stanley Howe's much publicized guest suite.



Looking down on the loggias of Lenox Hill Hospital, New York, an old building in which modernization miracles have been performed. A place to rest your weary soles and soul is the fountain-garden of Muhlenberg Hospital, Plainfield, N. J., a view from the private pavilion of which is shown at the right.

Another suggestion for a week-end stopover. You will find Mr. Howe a cordial host. While there, ask him to show you his scrapbook of newspaper clippings. This hospital has a way with newspaper editors.

A bit further off the main route at Paterson, N. J., there is something to be seen in cancer work. If this subject has an especial appeal, better arrange beforehand with Edgar Hayhow of Paterson General for an inspection of the comparatively new tumor clinics.

So far we have made no suggestions for any study of contagious disease service. Here is one now. You will find it at Belleville, N. J., at the Essex County Hospital for Contagious Diseases where the methods used and the physical plant designed for this service are noteworthy.

Soon we will be approaching Philadelphia, that is, if we choose the Atlantic City route that leads through that city. It would be unfortunate, too, when so near not to spend a short time at least looking about.

Just before going over the Camden Bridge, what do you say to a brief inspection of an efficient housekeeping department? For after all, housekeeping is rapidly becoming recognized as a major department in hospital organization. You'll find this rare specimen at West Jersey Homeopathic Hospital, Camden. Within the past year all sorts of experiments have been conducted in furnishings and painting, which have made the entire institution blossom forth in new gala attire. Mr. Gail, superintendent, bows his acknowledgments, sharing the plaudits generously with Mrs. Doris Dungan, executive housekeeper.

So this is Philadelphia! They haven't yet actually decided which institution bears the distinc-





Sweep away the scaffolding and you behold (at upper left) Queens General Hospital as it appears today. You may soon be walking through the visitors' room at Neurological Institute (lower left). One of Beekman Street's famed ambulance crews gives an emergency fracture treatment on the spot (above).

tion of being the first hospital in the United States, Philadelphia General or Pennsylvania. There is little doubt that the first almshouse infirmary was in existence almost two decades prior to the construction of Pennsylvania Hospital. There is likewise little doubt of the fact that the first incorporated hospital in the United States is the Pennsylvania Hospital. So take your pick—both are worth a visit.

The main building at Pennsylvania is the oldest in the country employed continuously for the care of the sick. Ask particularly to see the first clinical amphitheater in America, and the early implements used in the incarceration of the mentally ill, including Doctor Rush's "tranquilizing chair."

Let's also check up on present procedure. Ever hear of a father's clinic? John Hatfield, administrator, will tell you all about it, in fact, invite you to attend if one happens to be in progress. It prepares the father for what's to come and assuages his fears about midnight promenades.

Then, you will want to go through the suite of doctors' offices on the top floor of one of the buildings. Behind this project, too, lies an interesting story.

A similar pilgrimage should be planned to Philadelphia General, where many hours can be utilized to good advantage walking through the various departments comprising 2,000 beds and totaling \$7,000,000 in buildings.

That new surgical unit at Jewish Hospital also must not be overlooked. Again we would refer you, to refresh your memory, to The MODERN HOSPITAL of September, 1935.

But there is a limit to all human endurance. You are already surfeited with hospital sights, smells and thrills. Talk about a busman's holiday! Very well, we'll take leave of you, too tired no doubt to raise a protesting voice when we repeat—where would the big show be without its side shows? Also to add when in New York, call Ashland 4-2445 for other suggestions. "Yes, MODERN HOSPITAL speaking."

Administrative Case Histories

By E. MURIEL ANSCOMBE

MAINTAINING a consistent policy for the handling of visitors is a problem calling for great tact and diplomacy on the part of the hospital administrator. On the one hand, he must keep in mind that the public is uneducated in regard to limiting or supervising visiting hours. On the other, he must consider that both the patient and members of the hospital staff must be safeguarded from too frequent interruptions. At the same time he must be ever alert to keep the efficiency of hospital routine up to certain standards. To do this without friction requires determination, ingenuity and patience.

Another touchy spot, where tact is a requirement for smooth going, is the record room.

1. Controlling Visitors

STATISTICS regarding the number of people visiting hospital patients annually are appalling to hospital administrator and public alike. But is the caller aware of his injustice to the patient? Quite the contrary; he feels that, unless he remains at the bedside, he does not show solicitude.

We all know that nothing exhausts patients and retards recovery more than noise. The conspicuously placed "Quiet" sign has little effect, not because visitors disregard it, but because normal tones of the voice are intensified by the too frequent hard surfaces of hospital construction.

For the patient in the private room, with only one to be considered, there can be more latitude in visiting hours but the ward patient has no recourse when annoyed by visitors at the next bed.

The average visitor appreciates the need for restricting visiting hours once the reason is explained to him. But how are we to educate him? The many entrances to the modern hospital make it impossible for one individual to control visitors. Even if all visitors entered through one central point, no one, two or three individuals could control the situation. To supervise visitors properly, it would be necessary to have at least one individual cover each division but, with our present mounting administrative costs, we cannot employ sufficient personnel.

Engrossed with her many services to the patient, the busy nurse cannot control visitors.

Quoting a trite rule irritates the caller, whereas, if properly approached and given an explanation, he will willingly cooperate.

Why not organize a volunteer corps for this important phase of hospital work? Every community has a group of women with leisure time who are eager to assist the hospital. Utilizing their services during visiting hours will help solve the administrator's problem of controlling visitors.

Select a large group so that no volunteer serves more than one day a week. Two hours one afternoon is sufficient. If she serves several days a week, the work becomes monotonous and her enthusiasm wanes. The woman with a busy social calendar will not permit other engagements to interfere with her hospital days if she reserves only one afternoon each week for this work.

Before assigning work to the volunteers, the hospital administrator should give them at least two lectures. In these he should explain the importance of regular visiting hours, dwelling on the exhaustive treatments for the patients, medical rounds, nursing care and the fatigue caused by visitors in the hospital at all hours of the day. This preparatory course will impress the volunteer with the importance of her task and the reasons underlying it and will enable her to render a real service to the hospital.

Two women should be assigned to each division, one to direct visitors and the other to give the required explanations. A good plan is to place on the little table at which the volunteers sit a small alphabetical file for filing visitors' cards, two for each patient.

The visitor inquiring for a patient is given a card. When both cards have been given out, the volunteer knows the patient has two visitors. Subsequent callers are asked to wait for a few minutes. Then the volunteer asks the visitors at the bedside to shorten their visit to enable the next group to see the patient. At the close of the visiting period, departing guests leave the cards at the volunteers' table. When cards are not returned, the volunteer graciously reminds the visitors that "time's up." Lists of patients critically

ill or newly operated upon are supplied the volunteer to guide her in granting the special permission usually required in such cases.

Naturally discretion must be used in selecting volunteers. Just as "a soft answer turneth away wrath," so a pleasant, unhurried answer from a gracious, charming woman will usually placate the most surly individual.

Having the volunteer wear a uniform smock, with the words, "Volunteer Service," on the sleeve adds dignity to her service and confirms her official capacity. When the visitor realizes she is sufficiently interested in the hospital to give gratuitous service, he will cooperate instead of criticize.

This plan has been instituted with success in the Jewish Hospital of St. Louis and already has passed the experimental stage. Patients were quick to appreciate the surcease from prolonged visiting and, of course, the doctors and nurses acclaimed the plan at once. Soon visitors realized that the volunteers were rendering a truly helpful service to the patients.

The volunteer can aid the hospital in another way. Her weekly service acquaints her with many of the hospital's problems. By passing on some of the knowledge she has gained in the hospital, she can do much to make her community familiar with hospital needs.

This volunteer service has been a revelation. Visitors state that the whole atmosphere of the hospital has been changed and compliment us on the hospital's quiet, restful atmosphere. Especially has the service proved helpful to the nurses and physicians who can now devote their entire time to the care of the patient.

2. Medical Records by Cajolery

The record librarian's bugbear is the completion of records by the attending physician. No physician intends to neglect his records but the average man dislikes details. It is a tedious task to finish the records and it behooves the librarian to keep in as close contact with the physicians as possible.

It is impossible to secure the writing of good medical records without staff leadership. Physicians who do not require the prompt recording of laboratory findings by the hospital personnel cannot hope to render the type of scientific service the public has a right to demand. Methods of an alert librarian are soon reflected in the efficiency of the medical record room.

Unless interns are required to write medical histories and record laboratory findings promptly, a laxity will soon occur that is difficult to correct.

Granting all this, the medical librarian still has her difficulties, for the doctor is convinced he is the busiest of professional men. He has been told this so often that he accepts it as an axiom, even though he is tracked to his lair in the staff room and found to be discussing, in leisurely fashion, the improvement in his golf game. As a result, the librarian has to resort to wiles—first one and then another, for no trick works twice. Fortunate indeed is the record librarian whose department is in close proximity to the physicians' lounging room, as she can get in contact with the physician more readily.

Here are a few "dos and don'ts" for the medical record librarian:

1. Never give a physician a record that is in any way incomplete, except for his own notes.
2. Maintain a neat, orderly, attractive record room that is conducive to simple, easy work.
3. Do not become a nagger. A friendly smile, a spirit of cooperation and a sense of humor will go far toward enticing the physician into the record room.
4. Acquire a general knowledge of current medical journals and books in the library in order to be an intelligent listener and a worthy assistant.
5. Be vitally interested in each physician's specialty and solicitous in securing correlative current data. When the clever librarian meets a physician who is doing some research work on arthritis, for example, she can draw his attention to articles she has marked for him to read in recent journals. He will be appreciative of this and will reciprocate by completing that unfinished chart.
6. Don't fail the physician when he wishes to write an article on a series of cases; compile all required histories immediately in accessible form.
7. Do not leave a message for the physician to come to the record room as he is likely to forget it. Ask the registrar to notify you when he arrives so that you may casually meet him in the corridor and tactfully suggest that he has some unfinished records.
8. Know the hobbies and interests of the physician and use this information as a wile to lure him into your office. A bowl of unusual flowers may attract the attention of the physician who is a gardener at heart; a recent symphony or a new book of fiction may serve as a bait for others.
9. Most people appreciate sincere compliments. Do not hesitate to repeat a kind remark made by one physician of another's work. This will provoke further conversation pertaining to his work and add to your knowledge and value as a medical record librarian; and it will pay dividends in completed charts for your institution.

Looking at Labor Unions

By ARTHUR C. BACHMEYER, M.D.

WHEN a union of hospital maintenance employees was formed this spring in Augustana Hospital, Chicago, the Augustana trustees requested the Chicago Hospital Council to advise them regarding a sound policy of hospitals toward unions. This the council (with the Chicago Hospital Association cooperating) did through a committee that presented its final report last month. As chairman of this joint committee, I have been asked by The MODERN HOSPITAL to summarize the committee's recommendations.

The purpose of the study was essentially twofold. On the one hand, it was intended to acquaint all persons concerned in the operation of voluntary hospitals with such facts and issues as seem relevant to intelligent discussion of hospital personnel relations; on the other hand it was intended to serve as a guide for hospital administrators and trustees in establishing adequate personnel policies and practices in their respective hospitals. The study is, therefore, both factual and advisory, but does not in any way bind any of the member hospitals to any definite policy or practice.

Chapters I and II of the report are devoted to the rise of hospital unions both nationally and locally; chapters III and IV contrast and compare voluntary hospitals with industrial or commercial organizations; chapter V reviews the wages, perquisites and hours of 5,011 reported Chicago hospital employees; chapter VI treats of problems involving the common interests of both hospital employer and employee; whereas chapters VII and VIII treat of problems that concern primarily the separate interests of hospital employer and employee respectively. Chapter IX constitutes a summation of principles and recommendations.

Voluntary hospitals may be distinguished from ordinary industrial or commercial organizations in the following:

Nonprofit Character. The voluntary hospital is not organized for profit and no share of its sur-

plus, if any, inures to the benefit of any private individual. It owes its very existence to the philanthropy of the community—some of it expressed in money and a large part in service.

Vital Character of Service. Since human life is hanging in the balance in our hospitals all the time, hospitals must be prepared to meet any emergency that may arise.

Therapeutic Atmosphere. The value of hospital service often depends not only upon what is done but also upon how it is done. There must be a peaceful, quiet, confidence-inspiring atmosphere that will strengthen the patient's belief in the efficacy of the treatment received.

Educational and Research Responsibilities. Many hospitals play a large part in the training of medical students, interns, dietitians, nurses, technicians and, even in a few cases, domestic employees. This sometimes costs more than the value of the labor received, yet it is an important public service. A few institutions carry on research in clinical medicine to strengthen man's hand in his fight against disease.

Stability of Employment. Hospital employment is usually much steadier and subject to fewer fluctuations than commercial employment.

In contrast to these dissimilarities there are certain resemblances to commercial activity.

Large Employers of Labor. In the Chicago metropolitan area it has been estimated that there are some 15,000 to 20,000 nonprofessional employees of hospitals.

Only Source of Employee Income. The hospital is the only source of income for most employees and many of them consider this their life work.

Unfavorable Working Conditions. As a result of the charitable tradition, wages are frequently lower than in commerce.

Insecurity. Exemption from the social security act has deprived hospital employees of protection.

Chairman of committee on personnel relations of Chicago Hospital Council reviews report on a contentious subject

Paternalism. Employees sometimes resent the control exercised over their personal lives and the requirement that they must live and eat in the institution.

Decrease in Personal Contacts. Mass-production techniques adopted in some sections of some hospitals attenuate the personal factors binding an employee to his job.

Secularization. In most hospitals the maintenance work has lost all or practically all of its original religious character and often has little or no direct contact with patients. There is little atmosphere of self-sacrifice.

Issues Both Groups Must Face

The problems raised by the formation of unions may be divided into three groups, those concerning both hospitals and employees and those concerning primarily one but not the other. Five problems must be faced jointly:

Arbitration Instead of Violence. Strikes and stoppage of work in any form cannot be permitted in hospitals. The only possible basis upon which hospitals can deal with unions is predicated upon the complete and permanent renouncement of the strike. But if the strike, one of labor's most potent weapons, is renounced, the union will properly expect that suitable methods will be adopted for presenting and settling their requests. This requires self-imposed compulsory arbitration procedures as well as a spirit of confidence, trust, respect and understanding that will preserve the partnership of labor and philanthropy.

Jurisdictional Disputes. Since both vertical (*i.e.* industrial) and horizontal (*i.e.* craft) unions exist in the hospital field and furthermore, since both the American Federation of Labor and the Committee for Industrial Organization are sponsoring unions, there is real probability of jurisdictional disputes. Even were only craft unions involved, jurisdictional disputes would be possible. While it is not the right or the purpose of hospital administrators to dictate the choice of their employees in this matter, it is their right to assure themselves that the simultaneous existence of such unions should not lead to strife in the hospital or to hampering rules regarding duties.

Employment Procedures. Careful study must be given to employment procedures. Hospitals cannot bind themselves to any employment policy that will prevent them from getting the best possible grade of employees. Nor would union labor, which has a large stake in voluntary hospitals, wish them to do so. On the other hand, discrimination against union members should be avoided.

Discharge Procedures. No employee should be discharged because of union membership. If a

dispute arises over a discharge, a procedure for amicable and fair settlement should be provided.

Hours, Wages, Vacations and Other Conditions of Employment. These matters are the principal subjects around which negotiations will revolve.

Six problems relating to unions and to personnel administration primarily concern administrators:

Finances. More funds will be needed to meet higher pay rolls and shorter hours.

Selection of Employees. More careful selection of employees is essential when it becomes more difficult to discharge them.

Training of Employees. So that they may merit and receive promotion, opportunities should be provided for employees to receive additional training to the extent of their ability.

Personal Administration. The careful use of job analyses, job grading and personnel records should lay a basis for salary scales and for the promotion and discharge of employees.

Understanding of Hospital Work. Employees should be educated regarding the service, income, expenses and place in the community of voluntary hospitals generally and their own in particular. Nonprofessional employees, especially, need to get a "whole view" of hospital work.

Human Relations. Consideration should be given to the employee's point of view and the psychologic effect upon him of various administrative procedures. Small things often cause discontent.

The third set of problems must be faced primarily by the employees themselves:

Industrial Democracy. The first problem of the employee is: Shall I join a union? His decision should be entirely his own, reached without intimidation or coercion either by the administrator or the union. Obviously hospitals cannot permit use of "company time" for propaganda for or against the union.

Union Responsibility. Union officials should be accountable, both financially and in matters of policy, to the membership. Also unions must learn to observe their agreements conscientiously. If unions expect public support, their word must be good.

Employee Has His Rights

As conclusions we may state the following:

The rights of the hospital employee may be summarized as follows:

1. To discuss with the management, in any way he pleases, matters affecting his employment. This may be done personally or he may select some other individual, committee or organization to do it for him. Hospitals acknowledge the right of the employees to bargain collectively through repre-

representatives freely chosen by them without dictation, coercion or intimidation in any form or from any source. Hospitals will negotiate with such representatives, subject to recognition of the principle that the right to work is not dependent on membership or nonmembership in any organization.

2. To join or refrain from joining any lawful organization.

3. To receive wages as high as those which prevail generally in the Chicago hospital field and which approximate average wages paid in industry for similar work under like conditions, insofar as this is commensurate with the institution's financial ability. When hospitals provide board, room, laundry and hospitalization, such perquisites shall be valued at reasonable amounts considering both the cost to the hospital and the cost of comparable provisions if paid by the employees.

4. To have hours of work that are as short as the peculiar conditions of hospital service will permit, recognizing that emergencies may require over-time work. Hospital managements will endeavor to establish the following schedule of work wherever possible, (a) an eight-hour day, (b) a forty-eight-hour week, and (c) one full day's or two half-day's rest in seven.

5. To be employed steadily and continuously through the year subject only to variations in the demand for hospital service.

6. To receive due recognition of ability, efficiency, physical condition and personal habits in promotions, lay-offs and reemployment. Special consideration will be given to seniority and to the employee's economic responsibilities.

7. To receive health protection through physical examination, immunization and health service whenever necessary. Due regard will be given the assignment of employees to work to which they are physically fitted.

8. To have an opportunity either through education or experience to improve his skill, and to expect that the administration will continually review its salary schedules in order to correct inadequacies and reward increased ability.

9. To receive reasonable notice of discharge, or, in lieu of notice, a cash payment for the period.

Employee Has His Obligations

The obligations of employees must also be considered. Certain inescapable responsibilities and obligations fall upon a hospital. No one is forced to accept work in a hospital. When he does, he automatically shares in the assumption of these responsibilities:

1. To render loyal and efficient service for the full working period specified for his position and be ready, in genuine emergencies, to work as long

as may be necessary to safeguard the welfare of patients.

2. To follow faithfully the instructions of the hospital management.

3. To do everything possible to promote good feeling and pleasant relationships.

4. To give reasonable notice of intention to leave the service of the hospital, and after giving notice, to continue at work as usual for the remainder of his stay.

5. To refrain from any joint action with other employees that will cause any interruption of any phase of the hospital's service and to do nothing whatever to jeopardize the safety, welfare and recovery of hospital patients.

Policy for Vacations and Sick Leaves

All hospitals should adopt a definite vacation and sick leave policy. It is suggested that the policy be as follows:

1. One week's vacation with pay for nonprofessional personnel; two weeks for professional, clerical and administrative personnel and any persons exposed to special health hazards.

2. If the hospital adopts a plan of sick leave, it is suggested that one week be given to non-professional help and two weeks to professional, administrative and clerical workers and to any persons exposed to special health hazards. Some hospitals have found that the following regulation has been helpful. Sick leave should be granted only under careful medical supervision and required when needed as a protection to patients and other employees. Any sick leave to which an employee is entitled, if not used in one calendar year, should be added to the vacation period of the next succeeding calendar year.

3. Employees of less than one year to receive one twelfth of the scheduled vacation for each month of employment, but vacations to be granted only to those employees who have been in the employ of the hospital for at least three months.

4. Vacations to be granted as a preparation for future service; terminal vacations not to be granted.

5. Vacations to be taken during the period specified by the hospital.

6. The following holidays to be recognized by the hospital: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas. Persons who must work on these holidays should be given time off in the seven days preceding or following the holiday, whenever possible. If not possible, the day should be added to vacation. But holidays occurring during vacation period are to be counted as a part of vacation.

(Continued on page 77)

Constructed for the Crippled

By HOWARD WHARTON

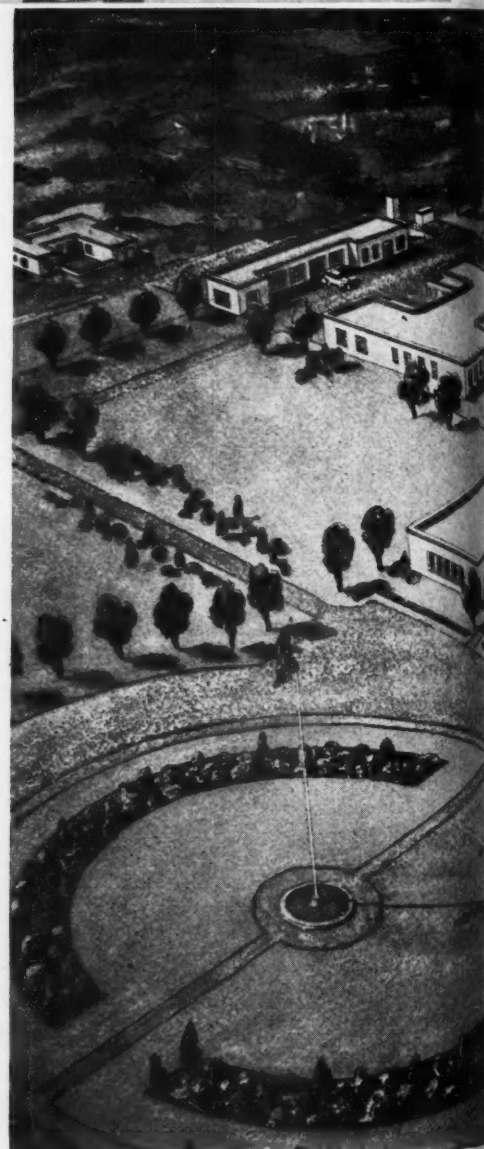
IN FEW medical fields has scientific advance been so rapid as in the specialized field of pediatrics. Notable progress has been made in orthopedic surgery and in hydrotherapy, resulting in new techniques and treatment for the crippled child.

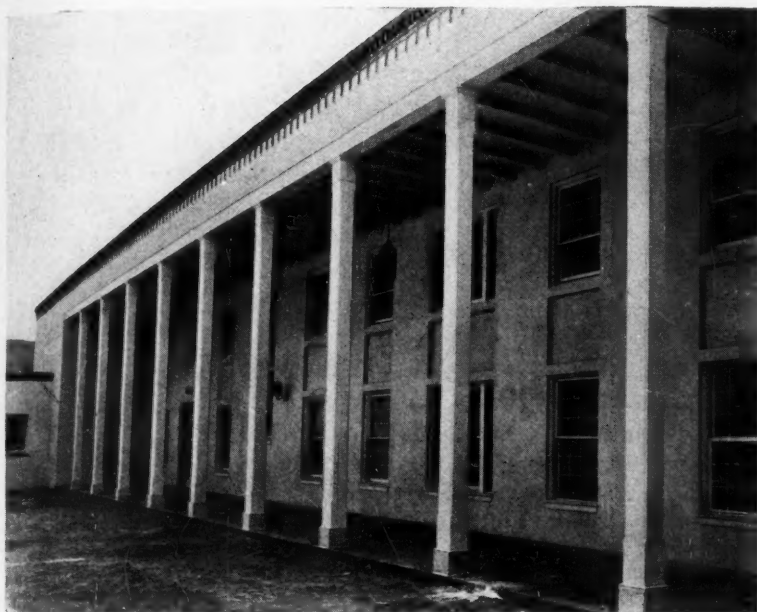
To carry on these treatments most effectively several hospitals are being constructed as Works Progress Administration projects. Equipment for the latest techniques has been incorporated. Location is planned to secure climatic advantages.

Inherent in the design and exercised in the program and daily routine of hospitals is the idea that the happier the child the better his chance of recovery. Everything possible is done to keep

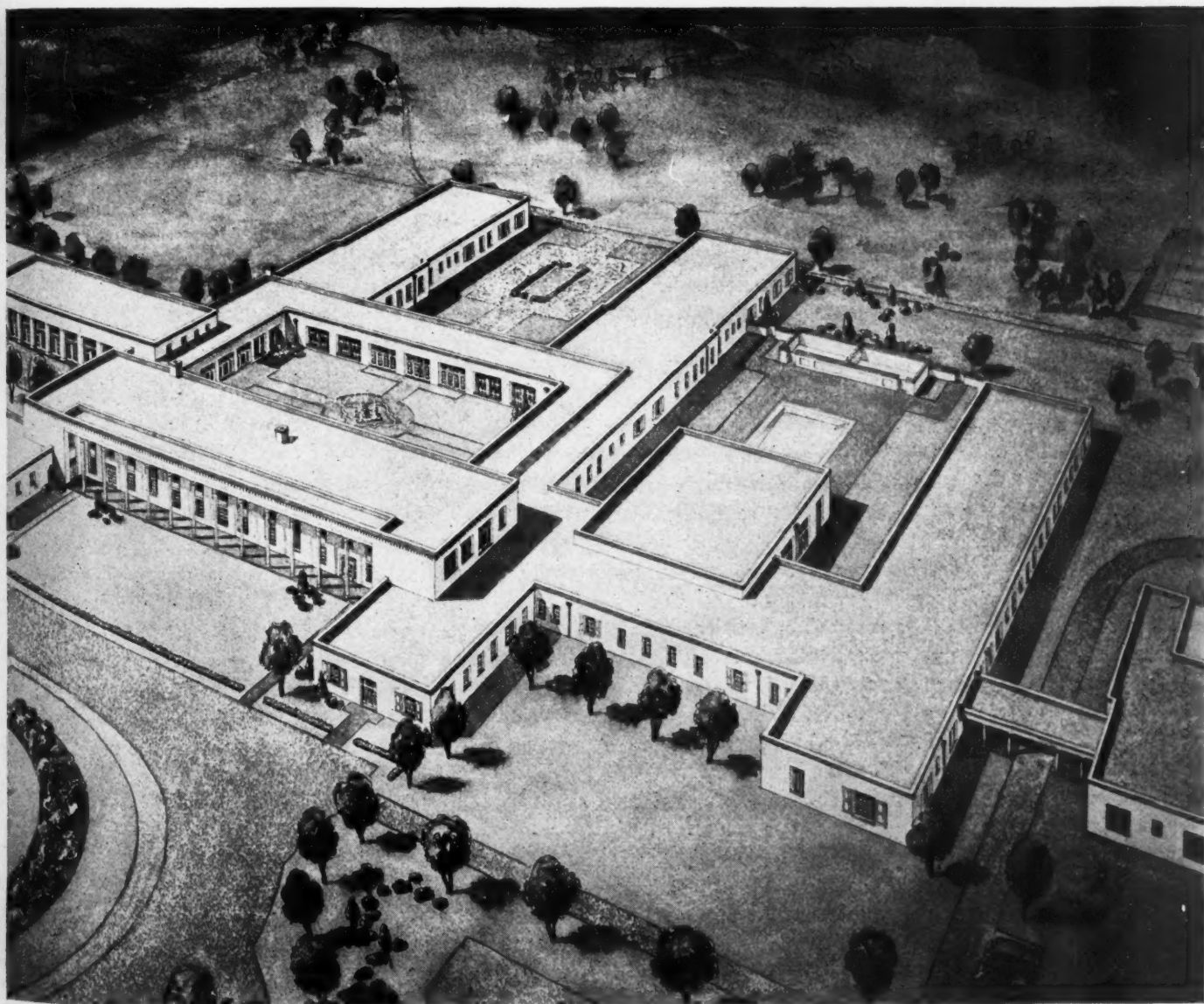


Famous "keyhole" tub, Carrie Tingley Hospital, Hot Springs, N. M.





Main façade, indoor pool and general layout, Carrie Tingley Hospital. The service wing extends on to the opposite page. The center section is administrative. Wards and private rooms surround the court at the back. The right court contains the outdoor swimming pool, with the indoor pool adjacent. Medical and surgical services occupy the wing at the right front.



the child contented and his mind occupied so that he has no inclination toward self-pity or a withdrawing into self. The idea of dependency upon others is minimized as much as is possible.

Several factors aid in this socializing process. The single story design permits the children on crutches or in wheel chairs to move about the hospital easily. The building up of confidence and self-dependence by the eradication of anything tending to produce a feeling of helplessness is important in the care and cure of these children.

Pride of New Mexico

Another factor, one of the best examples of its use being in the Carrie Tingley Hospital at Hot Springs, N. M., described in this article, is the use of colored walls and decorative motifs in the wards and throughout the hospital. The varied pastel shades of the walls, the decorating, the use of colors and designs to which the child's mind is responsive provide gay and pleasant surroundings having a definite psychologic effect.

The wards, not always conducive to recovery in all hospitalized cases, do have their good points in the care of crippled children. In the ward the child can see others like himself. He can talk and mix with them, play games such as checkers or become one of many listening to a group story teller. Thus any feelings of isolation, of helplessness or dependency are expelled by group interests that keep his mind occupied.

Further group recreation is provided in the recreation rooms in which the more able children enjoy games, stories and motion pictures. Education is also part of the daily program.

Certain segregation is necessary, of course. All of these hospitals have separate boys' and girls' wards, nurseries for the smaller children and isolation rooms for severe cases or cases entering with accompanying communicable diseases.

Throughout the entire scheme of these hospitals the utmost care has been taken to provide that no depressed mental states of the children will hamper the possibilities of curing or rehabilitating them.

During the first three years of operation the Carrie Tingley Hospital will treat only New Mexican children. A survey has disclosed that more than 1,200 are in need of treatment. The hospital, dedicated on May 29, 1937, was occupied in June. The staff at capacity includes seventy-five persons. Dr. F. C. Goodwin, specialist in orthopedics, is the chief attending surgeon. A dentist, general surgeon, attending staff and pediatrician have been appointed.

The first concrete was poured in March, 1936, on property deeded to the state by the city of Hot

Springs. The state penitentiary assisted in the construction by supplying 1,600,000 bricks. Henry Toombs, consulting architect for the Warm Springs Foundation, assisted Willard C. Kruger of Raton, architect, with the plans.

Cost of the hospital is estimated at more than one million dollars. The hospital has eighty-four beds and tentative plans call for a wing with thirty-two more. There are four ten-bed wards, twenty-four single rooms, six double rooms and two four-bed wards.

The dining room has a capacity of 100. It is designed with a stage at one end and a motion picture projection room at the other. Administration reception rooms, sun porches and recreation room are built around a patio. Hospital units are in the wings. There are numerous terraces and porches for sun baths, two cast rooms, occupational therapy rooms, operating rooms, and auxiliary rooms, an infirmary unit attached to the operating wing and treatment rooms.

The large outdoor swimming pool is enclosed on four sides. Connected with it are an enclosed treatment pool, tub rooms, rest and physiotherapy rooms.

Other facilities include plaster cast rooms, x-ray rooms, outbuildings for brace making, carpenter and electrical shop and a residence for the medical director.

No Stairs to Climb

The building itself is Spanish colonial style, covering 1.8 acres of floor space and so designed that an additional story may be added. As completed the building is one story throughout except for the administration wing, which has a second story for quartering the staff. The entire first floor of the hospital is built on a level with no ramps or stairs so that the children in wheel chairs or on crutches may reach any part of the building.

The two main entrances are equipped with iron grille chandeliers and grilled stairway railings designed to conform to the general plan and to add to the attractiveness of the building. Similar grille work is carried throughout the design.

Walls are constructed of washable, hard finished plaster with the corridors painted in ivory and the rooms and wards in varied pastel shades. Floors are laid with asphalt tile with the exception of the corridors, which are of brick. The operating rooms and the indoor pool are lined entirely with colored tile as are the washrooms and showers.

Fresh air and sunlight are assured with some 300 windows. Washed and conditioned air is circulated throughout the hospital and can be so con-

trolled that the severest of dust storms will not affect the interior.

The institution includes a \$20,000 electric kitchen, with additional basement equipment to augment that of the first floor. Kitchen equipment consists of range, pressure cooker, steam table, soup mixer, serving table, bake oven, ice cream mixer and freezer and ice making machinery. In the same wing with the kitchen are a complete laundry, servants' dressing room and a boiler plant for steam heat.

The mineral water used in the pools is supplied by a spring tapped at a depth of 130 feet and at a distance of 3,000 feet from the hospital. Having a high mineral content and a high degree of warmth it is extremely valuable in aiding the cures. Its temperature at the spring is 114°F., necessitating some cooling before it can be used in the pools.

The two pools, one indoor and the other outdoor, require 70,000 gallons of water. They are so constructed that recirculation of the water is possible at all times. Heavy iron gates at the junction of the two pools permit the closing off of the outdoor one in inclement weather.

The two operating rooms are each equipped with luminaires of 3,000 foot candle intensity and three degree luminosity. They are 42 inches in diameter, of holophane glass, with parabolic mirrors. Glass prisms reflect the light rays. Arc flashes that might cause explosion of any ether vapor present in the rooms are prevented by mercury tube switches connecting the current to the lamps.

The operating rooms are connected with a hallway lined with sterilizers for instruments and dressings which are subjected to 240° F. heat and 15 pounds' pressure. A tile curtain retains the radiant heat of the sterilizers during hot weather. An intravenous solution cabinet keeps saline preparations and materials for blood transfusions at body temperature. Another cabinet keeps blankets used in covering the children after operations at body temperature.

This Department Is Shockproof

The x-ray department is shockproof and contains radiographic and fluoroscopic equipment for diagnostic work. In addition there is a mobile x-ray unit with ample radiographic capacity for complete work in all wards and in the operating rooms. The fracture operating table is so designed that radiographic and fluoroscopic work can be continued during an operation. It can be moved into any part of the hospital.

Other equipment includes a key shaped paralysis tub. It is of stainless steel, thermostatically

controlled. Water can be ejected at an angle and with the proper force to assist in massaging by physiotherapists. The hospital is also equipped with a respirator room containing iron lung and auxiliary equipment.

The hospital was furnished with the necessary linens, towels and other cloth materials by sewing units of the WPA in the Hot Springs locality.

And Now to West Virginia

The Morris Memorial Hospital for crippled children is under construction at Milton, W. Va. When completed the hospital will cost approximately \$379,258. It is located on a farm and homestead deeded by W. T. Morris in perpetuity for the care and hospitalization of the crippled children of West Virginia.

Pending its completion, an orthopedic hospital was set up at Huntington, W. Va. At present, operations are performed at the Huntington hospital. The patients then are removed to the Morris Memorial Hospital for rehabilitation and cure. They are being housed at present in the old Morris homestead.

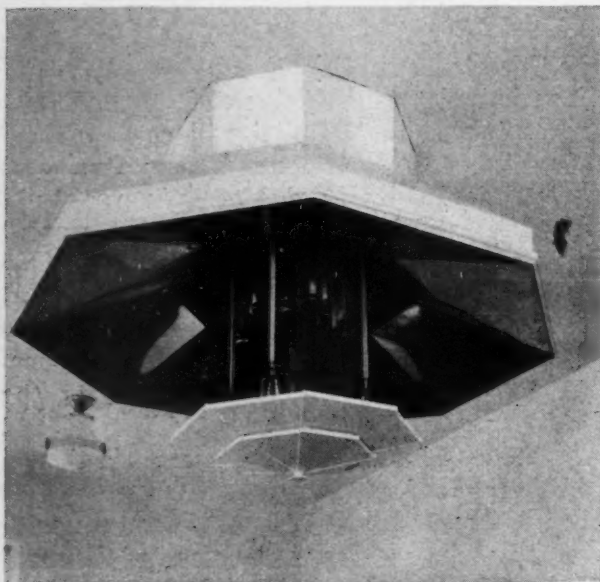
The new hospital is an L-shaped structure, with two oblique wings at the western end of the main administration and hospital building, and one at the eastern end, with the hydrotherapy building and the school building annexes forming the base of the L on the southeast. Construction is being executed in units. So that the patients already housed in the old hospital might have pool facilities as soon as possible, the hydrotherapy building was the first unit constructed. Also included in the first unit was a model dairy barn.

The hydrotherapy building, designed to fit into the entire architectural scheme, is constructed of hard, blue-white native sandstone. Roof beams are of steel and the two pools, each 24 by 36 feet, are of stone and cement.

Salt water of the proper quality, so necessary to the relaxation and exercise of crippled limbs, is found near the hospital at approximate depths of 1,000 feet. Being slightly heavier in salt content than that found along the Atlantic Coast, this water has excellent buoyancy. The water is piped from artesian wells to the hospital where it is heated before it is used in the pools.

In addition to the large pools, the hydrotherapeutic building contains a smaller pool or tub in which spastic paralysis cases can be treated. The arrangement and size of the pool permit the attendants to assist in supporting these almost helpless patients. By relaxing in water much hotter than that of the other pools the nervous jerking of the spastic-paralytic is reduced sufficiently often to permit control of the muscles.

Two views at Betty Bacharach Home, Longport, N. J., one showing the carbon sun lamp in the heliotherapy ward and the other the hydrotherapeutic pool. Sterilized sea water is changed in this pool every three and one-half hours.

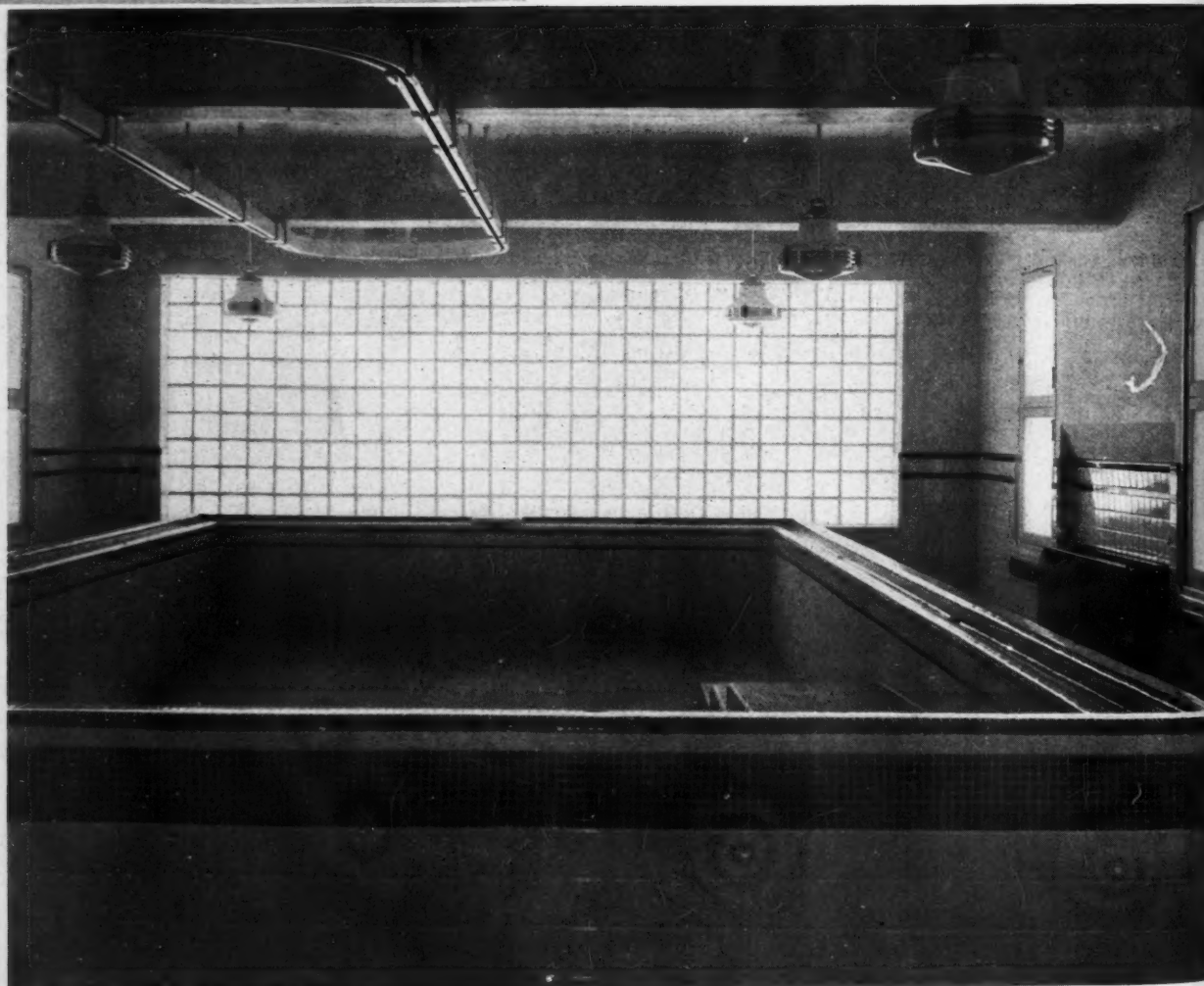


Nearing completion is the western unit of the main hospital and administration building. The main portion of this unit measures 142 by 38 feet while the two wings are each 60 by 24 feet. Stone construction similar to that of the hydrotherapeutic building has been used throughout. Located in this unit are wards and private rooms having a capacity of seventy-five beds.

Further construction will entail the erection of the large central administration building with operating rooms, living quarters, clinics and offices; the school and handicraft building, and the second or eastern wing, bringing the total capacity to 150 beds. It is also planned to erect a series of cottages close to the hospital to house visiting parents and relatives of the patients.

Fruit orchards, fields of vegetables, a herd of tested cows and flocks of chickens make possible a low average cost of \$2 per day per patient. This compares favorably with the national average for similar type of work of \$4.50 per patient per day worked out by the American Hospital Association.

The hospital will not be operated for profit. Medical staff and advisory board, together with the hospital governing board, serve without pay.





Crippled Children's Hospital, Knoxville, Tenn., is another of these hospitals built with WPA funds, on a site contributed by Fort Sanders Hospital. Young patient and nurse are being photographed for the Knoxville News-Sentinel.

Another hospital for crippled children has been built by WPA at Knoxville, Tenn., aided by the American Legion, the Shrine and Knox County. The land for the site was contributed by Fort Sanders Hospital, the facilities of which have been available for crippled children in emergencies.

The new hospital includes a therapeutic pool, similar to the Warm Springs pools, a violet-ray room, dietetic kitchen, school room and a glass examination room. The glass examination room was decided upon in order that frightened children, facing an operation, can see cheerful patients who are recovering from the same ordeal.

Another project, an addition to the Betty Bacharach Home for Crippled Children at Longport, N. J., has just been completed by the WPA. Its therapeutic pool with a capacity of 15,000 gallons is constructed of white tile and has a skidproof bottom. The pool is 12 feet wide and 22 feet long. Sterilized sea water will be changed every three and one-half hours. Physiotherapists will treat patients in the pool on stainless steel apparatus.

The addition also contains four treatment rooms, four dressing rooms, an office, consulting room, rest rooms and cubicles. A sunlight room with a carbon lamp treats a dozen at one time.

With the Roving Reporter

The Bells of Mayo

• Ever hear the bells of Mayo? If not, you have a treat in store. Better plan to reach Rochester, Minn., however, in time to find a place to park comfortably. Three days a week in the late afternoon the crowds begin to gather expectantly. They gaze twenty-one stories above to the tower of Mayo Clinic from whence come the ringing, throbbing tones of the carillon.

The half-hour concert ended, you will want to be introduced and extend congratulations to James J. Drummond, administrator of the Worrell Hospital, who is also an expert carillonneur, probably the only hospital executive in the country who goes in for ringing bells in a big way. Mr. Drummond will be glad to initiate you into the intricacies of the job. And if anyone thinks that running a hospital is tough work, let him watch Mr. Drummond at play.

First he dons light shirt and trousers, for even on a cool day playing the carillon induces copious perspiration. It is a distinctly athletic type of artistry—a half-hour concert equaling eighteen holes of golf.

There are twenty-three bells in all, the largest weighing four tons and the smallest 168 pounds. The clapper of each bell weighs one-sixteenth of the weight of the bell.

But that's only half the problem.

No two sets of bells are just alike, hence every carillonneur must make his own musical arrangements. Mr. Drummond, for example, has built up an extensive library of pieces adapted to his own particular set of bells and of transcriptions that he or his friends have prepared. A maximum of six bells can be struck at any one time, two with each hand and two in the lower register with the feet.

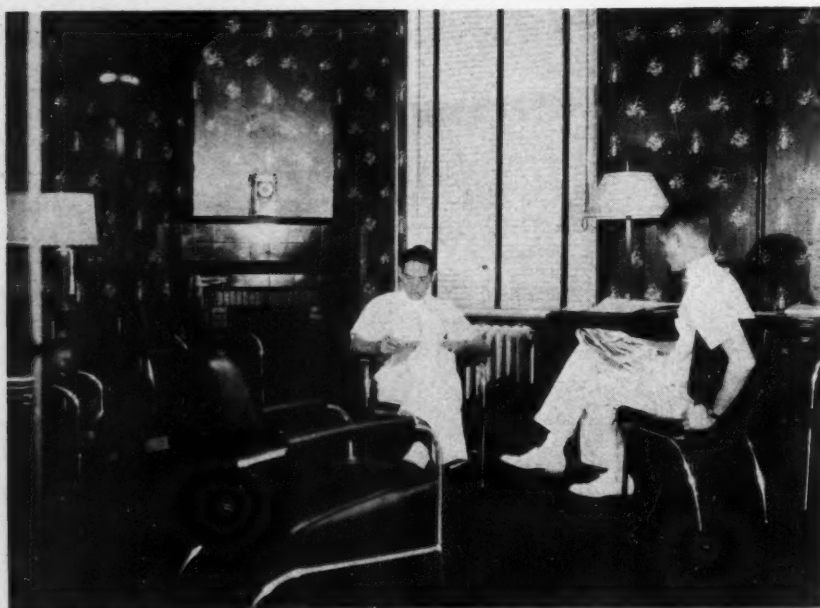
What more effective hobby by which a hospital administrator can forget his troubles! Mr. Drummond's concerts on the bells of Mayo are enjoyed by thousands and have made the neighboring countryside hospital conscious.

All for the Doctors

• They stopped us short last month before we even had a chance to tell about that doctors' lounge or staff room at the Children's Hospital in Buffalo, N. Y. We got only as far as describing Mrs. Evangeline Nye's cool, restful foyer done in blue and white.

You would never believe it was once the pharmacy and a private room. The space is well located on the main corridor just to the right of the entrance. Mrs. Nye had her eye on it for a long time and determined that as soon as suitable arrangements could be made the doctors should have a place they could call their own.

The accompanying photograph



Doctors at Children's Hospital, Buffalo, N. Y., in their new lounge.

doesn't half do it justice. The color scheme is black and red and the general design is modern. Chairs, for example, are metal, upholstered in black leather. A substantial desk against one wall provides space for newspapers and magazines and there is a comfortable sofa with a side table and lamp—ideal for a few minutes' relaxation. The ceiling has been acoustically treated in the manner of all good modern ceilings. That, in fact, constituted the only major expense. Needless to add, the doctors are enthusiastic.

About Guarantors' Funds

• Before leaving Buffalo on this trip a few words with Dr. Fraser D. Mooney, superintendent, Buffalo General Hospital, on guarantors' funds raises certain questions that are well worth thinking about. This hospital's fund was started about twenty-two years ago.

"It works out well," Doctor Mooney explains, "except that we find that if we call for the full amount of the pledge a considerable number immediately drop from the list, although of course they pay the pledge for that year. We believe that the person who signs a pledge for one or more shares at \$25 and finds that he has to pay less than that amount, say for example \$15, believes that he is saving \$10 and will renew. Also if we break even and call for no guarantee, he is less liable to renew his pledge, possibly for the reason that he thinks his help is not needed.

"I have often thought," Doctor Mooney adds, "that there might be justification in having a \$10 guarantee share rather than a \$25 share for the reason that many people might take a chance on having to pay \$10 whereas they feel they could not afford \$25. In my opinion the fact that the person contributes will make him consider that hospital 'his hospital' and that is worth infinitely more to that hospital than the money he gives."

There is always the problem, too, of finding new names to take the place of those who feel they cannot afford to continue. Doctor Mooney finds that a good way to do this is to choose from the published lists of donors to the "joint charities," or what might be called in other cities the community chest, those who have given \$100 or more. These are gradually developed into a list and contacted, preferably in person by a member of the board who happens to know them personally. If that is impossible, prospective donors may be reached by letter.

They've Turned "Pro"

By FRIEDA CLAUSSEN, M.T.

THERE is no Florence Nightingale to mark the birth of medical technology. Out of the chaos existing in the laboratory field at the time of the World War when young men and women with indifferent educations were drawn from the civilian population to serve the urgent need of army laboratories, where they necessarily received short instruction, have gradually developed the order and system that prevail today, with their accompanying high standards and resultant efficiency in the laboratory field.

For bringing this order out of chaos, the medical technologist in particular and the medical profession as a whole are deeply indebted to the American Society of Clinical Pathologists, an association of physicians specializing in laboratory medicine. In 1928, this society decided to establish a central agency for testing the competency of laboratory technicians and to issue certificates of qualification to those who passed muster. Accordingly, they appointed a National Board of Registry to receive applications for registration, to conduct examinations, to issue certificates and to conduct a survey of technician training schools, gradually raising the prerequisite education, the standards of approved training schools and standards of the medical technologists themselves.

The work accomplished by this board of registry in the last nine years is stupendous. Physicians and hospitals who deal directly with the laboratory technician are no less indebted to these men than the medical technologists themselves. With each year the number of applicants for registration has grown, until the present roster carries nearly 4,000 names, about one-third of the technicians in the United States and Canada.

Registration Not Compulsory

Though registration of technicians is not a compulsory affair, the American Medical Association and the American College of Surgeons in their inspections of hospitals for eligibility for internship and the fulfillment of minimum requirements

Out of the amateur into the professional class have come the medical laboratory technicians. Certification by a national board of registry has brought them new respect from physicians and hospital administrators

stress the necessity of having the hospital laboratory personnel carry a certificate of qualification from the Registry of Medical Technologists, and even professional placement bureaus now prefer certified applicants.

After the formation of the central registry the next step in organization was inevitable. In the spring of 1933 a group of registered technicians decided to hold a meeting to form an American Society of Medical Technologists. This society, which is composed of registered technicians only, is endeavoring to encourage and promote research and improved clinical laboratory methods, and to further cooperation with the medical profession in the field of laboratory medicine. The society is only in its infancy, and so far few medical technologists have joined. However, this group has held a number of successful conventions (held at the same time and place as the annual A. M. A. sessions so it might be benefited by the exhibits), has launched a small journal and is well on its way to affiliating the state organizations.

Few Tests Are Infallible

The relation of the technician to the hospital has points in common with practically every other hospital group. With diagnosis as the central objective, the welfare of the patient as the main motive and the attending physician as the intermediary, a triad is formed that is, or should be, the common feature of all clinical laboratories.

Time was, when the physician had to depend entirely upon his own clinical findings for diagnosis. With the help of the thermometer and stethoscope, and the aid of his eyes, ears and hands, he was obliged to seek his way more or less

blindly through the darkness confronting him. Now his path is gradually becoming illuminated, and the part played by the x-ray and clinical laboratory findings is immeasurable in its greatness.

On the technician falls the task of bringing to light the many hidden helps and hints that serve as a proper guide in diagnosis. In the beginning, tests were few and simple. Today they are so numerous and so constantly increasing in number, that it is a task to keep up with the new, to improve and simplify the old and to weed out the impractical and undesirable from the maze of literature and research.

Unfortunately, workers in the laboratory field must contend with the fact that few laboratory tests are absolutely infallible. Even with great accuracy, care, precaution and the most ideal working conditions, there are factors that, if not minutely watched and controlled, will throw off an entire test. The wise physician realizes this and never depends with absolute certainty upon any one laboratory finding. If reports agree with the clinical symptoms, they serve as confirmation. If they disagree, they should be checked and rechecked before being taken at their final worth.

Need Supervision and Counsel

All this shows the importance of having alert, careful, conscientious, dependable and well trained workers on the laboratory staff. In a well run clinical laboratory, the technologist is responsible only to the pathologist or director of the laboratory. Any criticism or suggestion should come through him. On the other hand, the director must be willing and able to shoulder responsibility and to act as a buffer. Many technicians in smaller hospitals have no adequate supervision or counsel of a competent director.

This situation is difficult to solve in a satisfactory way. The American Society of Clinical Pathologists, the American College of Surgeons, the American Medical Association and thinking medical leaders are earnestly striving to solve this vexing problem. For the present, the consensus appears to be that, in addition to training medical technologists in all phases of laboratory technique and instructing them to refrain from rendering diagnoses and opinions, the type of person should be chosen who fully appreciates his own limitations and possesses the initiative to act independently when the occasion arises.

To refrain from rendering a diagnosis, except insofar as it is self-evident in the report, is part of the code of ethics of the registered medical technologist, and is a point that should not be overlooked in the relationship of the technician to

the physician. In this age of multitudinous laboratory procedures, it is often difficult for the physician, especially the present day specialist, to interpret the findings of every laboratory test.

An amusing example is the story of a doctor who sent a specimen of blood to a laboratory for a Wassermann test. The report was sent back to him—Kolmer, 4 plus, and Kahn, 4 plus. He wrote an irate letter to the director of the laboratory stating, "You sent me back the wrong report. I have no patient by the name of Mr. Kolmer or Mr. Kahn."

This is easily understood in view of the existing circumstances, and accounts for the fact that the physician will often come to the technician with such questions as, "Just what does this report mean? Does this mean that my patient has infectious mononucleosis?" Or again, "What about that smear? Does it show positive evidence of pernicious anemia?"

When there is no pathologist at hand to whom the doctor may be referred, it sometimes takes infinite tact to make the proper reply. The technician must keep in mind always that he sees only half of the picture and that the clinical side of the picture, which he does not know at all, is still the more important half.

The technician must be tactful, too, in dealing with the patient. Often he must think up a quick, evasive answer when the patient confronts him point blank with "Just what is that test for?" or, "What did my blood test show yesterday? You might as well tell me, the doctor will tell me anyway?" or, "Is my blood sugar improving? After all I have a right to know. I'm the one that's paying for these tests."

Getting Along With Nurses

Cooperation between technicians and nurses is highly essential for the efficiency of hospital routine. Each one believes his work the more important of the two. It is often irksome to a nurse to be interrupted during a bath or rub to wait for a technician to take a blood test. Yet, if the technician had to wait for a moment when there would not be an interruption, the doctor might have to wait unduly long for his report. It is often irksome to the technician to be called to the telephone a dozen times for reports that are not ready, yet it must be kept in mind that the nurse is only doing her best to give the physician the best service.

The technician who shows toward the patient, the physician and hospital employees tact, courtesy, kindness, tolerance and patience, and who shows accuracy and speed in rendering reports, is the technician who will make a reputation for the laboratory and the hospital.

That Laboratory Budget

By H. R. FISHBACK, M.D.

WITH a view to providing a tentative basis of judgment regarding the laboratory budget and of the value of laboratory personnel, a questionnaire was submitted to hospital laboratories in various parts of the United States.

It is hoped that the findings of this study will be of value especially with newly projected laboratory services in new or old hospitals, and still more if the laboratory income is to be obtained in some manner other than by direct charge per test.

As a basis for comparison a survey was made of forty-six hospitals. Data were obtained from hospitals with from 100 to more than 300 daily patients. Government, city and county hospitals and all those hospitals financing their laboratories by methods other than by charges on the patient were omitted from the survey.

In considering data, laboratories were divided according to average daily patients in the hospitals into three groups: less than 150, from 150 to 200, and greater than 200. Averages were made from these groups. Also the several hospitals that reported losses in laboratory operation were grouped separately according to size.

In addition a study was made of hospitals divided according to geographical distribution into East, South, Midwest and West groups. Averages were made from statistical items weighted for the number of daily patients. Nothing of significance was added to the results obtained from the size grouping, and the geographical data are therefore not included. Laboratories declaring a profit are considered first.

Laboratory personnel gradually increased with increasing number of patients from 0.97 physicians and 2.7 technicians in the smallest group, to 2.1 physicians and 3.2 technicians in the group of largest hospitals. Altogether there was one physician to 122 patients. The daily average of patients cared for by one technician varied from 52.2 (Group I) to 70.6 (Group II) and 97.8 (Group III). Altogether the average number of patients per technician was 63.6.

| L A B O R A T O R Y H O S P I T A L | GENERAL | LESS THAN 150 PATIENTS | | 150 TO 200 PATIENTS | | OVER 200 PTS |
|-------------------------------------|---|------------------------|----------------|---------------------|----------------|---------------|
| | | WITH PROFIT | | WITHOUT PROFIT | | OVER 200 BEDS |
| | | WITH PROFIT | WITHOUT PROFIT | WITH PROFIT | WITHOUT PROFIT | WITH PROFIT |
| INCOME | NUMBER OF HOSPITALS | 21 | 5 | 10 | 5 | 5 |
| | NUMBER OF BEDS | 185 | 206 | 271 | 230 | 370 |
| | AVERAGE DAILY PATIENTS | 116 | 124 | 174 | 176 | 237 |
| | ANNUAL PATIENT DAYS | 42,300 | 45,250 | 63,500 | 64,240 | 93,800 |
| | FROM PATIENTS | \$117,800 | \$62,665 | \$245,112 | \$227,298 | \$325,800 |
| | FROM OTHER SOURCES | \$36,900 | \$46,147 | \$12,553 | \$6,832 | \$103,989 |
| | TOTAL INCOME | \$254,700 | \$208,812 | \$336,365 | \$324,130 | \$429,789 |
| | TOTAL EXPENSE | \$249,200 | \$200,630 | \$321,857 | \$336,651 | \$424,881 |
| | ANNUAL PROFIT | \$5,500 | \$8,182 | \$14,508 | \$-2,521 | \$4,908 |
| | PERCENT PROFIT | 2.16 | 3.91 | 4.31 | -0.78 | 1.14 |
| EXPENSE | NUMBER OF PHYSICIANS | 0.97 | 1.2 | 1.3 | 1.5 | 2.1 |
| | NUMBER OF TECHNICIANS | 2.7 | 1.8 | 3.0 | 3.0 | 3.2 |
| | AVERAGE PATIENTS PER WORKING DAY PER TECHNICIAN | 52.2 | 83.6 | 70.6 | 71.4 | 97.8 |
| | NUMBER OF TESTS PER WORKING DAY PER TECHNICIAN | 31.6 | 29.6 | 29.6 | 39.9 | 44.8 |
| | VALUE OF TECHNICIAN'S WORK PER WORKING DAY | \$19.45 | \$11.56 | \$16.00 | \$8.70 | \$18.20 |
| | TOTAL NUMBER OF TESTS | 25,564 | 24,586 | 26,650 | 35,875 | 43,072 |
| | PERCENT PAID | 68 | 34.4 | 66 | 37 | 38.3 |
| | PERCENT FREE | 32 | 65.6 | 34 | 63 | 61.7 |
| | NUMBER OF TESTS PER PATIENT DAY | 0.60 | 0.54 | 0.42 | 0.56 | 0.46 |
| | LABORATORY INCOME | \$15,710 | \$6,246 | \$14,318 | \$7,836 | \$16,192 |
| LABORATORY EXPENSE | PERCENT OF HOSPITAL INCOME | 6.2 | 3.0 | 4.3 | 2.4 | 4.2 |
| | INCOME PER WORKING DAY | \$32.37 | \$20.82 | \$47.73 | \$26.12 | \$62.64 |
| | INCOME PER PATIENT DAY | \$0.37 | \$0.14 | \$0.23 | \$0.12 | \$0.19 |
| | INCOME PER TEST | \$0.62 | \$0.25 | \$0.34 | \$0.22 | \$0.42 |
| | SALARIES | \$6,237 | \$6,314 | \$8,192 | \$9,090 | \$9,631 |
| | SUPPLIES | \$1,397 | \$2,306 | \$1,551 | \$1,374 | \$1,572 |
| | MAINTENANCE | \$96 | | | \$466 | |
| | TOTAL EXPENSE | \$8,620 | \$8,620 | \$9,743 | \$10,930 | \$11,203 |
| | PERCENT OF HOSPITAL EXPENSE | 3.3 | 4.3 | 3.0 | 3.2 | 2.6 |
| | EXPENSE PER WORKING DAY | \$20.75 | \$29.40 | \$32.40 | \$36.45 | \$37.34 |
| | EXPENSE PER PATIENT DAY | \$0.20 | \$0.20 | \$0.15 | \$0.17 | \$0.12 |
| | EXPENSE PER TEST | \$0.34 | \$0.36 | \$0.37 | \$0.31 | \$0.26 |
| | ANNUAL PROFIT | \$7,090 | \$2,374 | \$4,575 | \$-3,094 | \$6,907 |

The apparent increase of efficiency in the larger hospitals is offset to some extent by the fact that in the smaller hospitals more tests are done per patient day, the averages for the three groups being 0.60, 0.42 and 0.46. The final advantage still rests with the larger units, however, in the total number of tests done by each technician in a working day, the group averages being 31.6, 29.6, and 44.8.

The expense of running a laboratory in the small hospital is much greater, in proportion to the daily patients in the house, than it is in the larger hospital. Totals for the three groups are \$8,620, \$9,743 and \$11,203. Also the percentage of total hospital expense represented by laboratory expense decreases as the size of the hospital increases, the figures being 3.5 per cent, 3 per cent and 2.6 per cent.

Salaries naturally make up the greater proportion of the expense, from 72 to 86 per cent being paid for this item. The monthly bill for supplies in the three groups is \$116, \$129 and \$131. Maintenance and other charges were not listed in a considerable share of the reports. When given they varied widely without regard to size or location of hospital, or to amount of laboratory work

done, so that comparison was hardly possible. Using the given figures on expense for calculation it is found that the laboratory expense per working day in the three groups is \$28.73, \$32.48 and \$37.34. The expense of running the laboratory per patient day is found to be roughly 20, 15 and 12 cents. The differential in favor of the larger hospital in both the foregoing items is not entirely due to increased efficiency, but in part to the fact that fewer tests per patient day are run in the larger hospital. The expense per test averages 34, 37 and 26 cents, thus conforming to the usual expectation of lower cost with increased volume of work.

The average laboratory income in the three groups is \$15,710, \$14,318 and \$18,192—a very small difference considering the size variation of the hospitals in question. In relation to the total income of the hospitals the foregoing given laboratory income averages are 6.2 per cent, 4.3 per cent and 4.2 per cent.

The two most significant factors in the low range of income variation are these: First, the number of tests per patient day in the smaller hospitals is considerably greater than in the larger hospitals. Second, the laboratory income per test is considerably greater in the smaller hospitals, the amount for the three groups being 61.5, 54 and 42.2 cents per test. These two factors, taken together, are enough to offset to a considerable degree the greater number of patients in the larger hospitals. The laboratory income per patient day of 37.2, 22.6 and 19.4 cents is also seen to be lowered in the larger hospitals, corresponding to the variation in the other items given above.

There were a few hospitals in each group whose laboratories were run at a loss. The average losses given are \$2,574 (Group I) and \$3,094 (Group II), a considerable item in view of the amount of work done. In explanation of the losses declared, the significant factor appears in the percentage of free work done. Whereas in the profit groups the ratio is about two-thirds paid to about one-third free work, it is almost reversed in the loss groups with about two-thirds free work.

It was thought that if such difference developed in the laboratory incomes, some association might be found in the amount of income of the hospitals other than that from patients. It is true that in the smaller hospital group those with laboratory profit had much less of such other income than those with laboratory loss, the percentage of the total hospital income in the two groups being 14.5 and 22.1. However, the hospital profit was about the same. The remainder of the hospital group showed no wide variation of nonpatient income as compared to expense.

A glance at some of the figures given for the laboratories carried at a loss, such as total tests and the expense items, gives evidence that they have not been such a burden to their hospitals as the red ink would indicate (See table). Laboratories in such situations might feel their positions improved if they kept accounts of the value of all work done by them, as well as the incomes accredited to them.

The laboratory profit is seen to be the greatest in the smaller units, and this is apparently due chiefly to better income per test and higher percentage collection. In another issue the competition the laboratory faces will be considered.

Postoperative Infection

Possibly no phase of hospital recording is less complete than that pertaining to postoperative wound infections. Both the surgical staff and the administration appear to be equally hesitant to admit that such infections occur. Deaths may be made the subject of rigid investigation and even "spotlight" explanation, but the postoperative infection is soft-pedaled almost to the point of non-existence.

The use of a printed form is one method, in effect for many years, that gives a close picture of actual postoperative conditions in this respect. It is, of course, based on the human factor in its recording, but errors of omission can readily be checked from the history and the nurse's notes.

The form, 4 by 7 inches, is titled "Report of Suspected Infection" and bears the signature of the supervisor. On it is a blank line to be filled in for each of the following points of information: name, number, ward, nature of operation, date, surgeon, first assistant, instrument nurse, sponge nurse, date of first dressing, dressing doctor, dressing nurse, date of appearance of infection, and location and character of infection.

This report of a suspected infection is made out in every case of a closed wound which for any reason whatsoever opens up or discharges. The form is sent to the operating room and from there checked with the surgeon and the patient's history as to whether it is properly chargeable as a postoperative wound infection or not. For example, a pus appendix closed tightly or an infected broad ligament are preoperative infections, whereas infected chronic appendix, hernia, gastro-enterostomy, closed gall bladder and cesarean section are operative or postoperative infections.—*G. F. Stephens, M.D., and H. Coppinger, M.D., Winnipeg General Hospital, Winnipeg, Canada.*

Getting Good Social Workers

Six suggestions for tax-supported hospitals to improve their medical service to patients

By IRENE GRANT

THE increasing public support of the merit principle in appointments to organizations that are tax-supported undoubtedly is regarded with favor by public hospitals. The quality of the personnel is the largest single factor determining the quality of the hospital's service to its patients. Of all tax-supported agencies, a hospital probably can least endure the spoils system.

The securing and retaining of good social work personnel under civil service involve several factors. First is the interpretation of needs to several separate groups—the hospital medical staff; the classification and budget authorities; the schools of social work and other social agencies, and most important of all, the civil service commission.

Medical Staff Support Essential

The first responsibility in connection with personnel standards is to be sure of the sympathetic and aggressive support of the hospital medical staff. If staff members place a high valuation on social work they will help demand the high qualifications required in the work that is so inextricably interwoven with their own. Their professional support in approaching the civil service commission is a most valuable protection to social work standards.

Second, it is necessary to interpret standards to the classification authority both within the hospital organization and the civil service commission. There may not be such an authority in every public hospital or system, but there probably is such an authority connected with most civil service commissions. This person or board classifies positions in an orderly manner by general services, such as professional and scientific, sub-professional, administrative and custodial. Additional grades within these services take care of relative responsibilities, education and experience requirements. The board also establishes salaries.

The idea behind classification is equal pay for equal work. The two problems that arise most

often in this connection are probably the value of social work as compared to other positions and the relation between the responsibilities carried and the qualifications demanded.

There is need to demonstrate to the classification authority the professional character of medical social work—the responsibilities and duties involved in the practice of case work; in the developing of a medical social program within a medical organization; in participating in the development of health and social programs in the community; in an educational program for professional personnel, and in medical research.*

It is important that the classification authority be supplied with data as to the professional education and experience in the specialized field of medical social work considered by outstanding hospitals over the country as essential for the fulfillment of such activities. It is well to know also how other professional positions have been classified and graded in order to uphold adequate social work salaries.

The third group is the budget authority, which in the case of a single hospital may be the hospital administrator himself. Upon this group rests the responsibility for preparing the statistical material that definitely proves to the appropriation committee that a certain amount of tax money is needed for salaries. Adequate statistics which have meaning to the budget office are therefore a necessity in obtaining funds for salaries that will attract well equipped candidates.

The fourth and fifth groups to which there must be interpretation of needs, if satisfactory candidates for the examination are to be obtained, are the schools of social work and other social agencies. While major responsibility is usually

*See statement of standards published in 1936 by the American Association of Medical Social Workers, 844 Rush St., Chicago.

supposed to lie with the civil service commission, hospitals, if they want good personnel, must get the schools interested in their personnel problem. It is necessary to gain the schools' cooperation in preparing students for this field thoroughly and in encouraging promising students to enter public hospitals. Their help is needed in the form of suggestions of talented graduates whose interest in taking the examination may be gained.

With about one hundred medical social workers graduating from the schools in a year, there is competition among all hospitals, public and private, to secure these graduates. When opportunities are so many and offers so numerous, it is hard for tax-supported hospitals to induce these graduates to bother with an examination.

One of the solutions would be to encourage more students to take up medical social work. On the other hand, the schools sometimes have to limit the number of students because of insufficient or inadequate training in field work. The success of recruiting, therefore, comes straight back to the quality of work the tax-supported hospital is doing. There is responsibility for doing work of such good quality that the schools can use public hospitals for training in field work. This would undoubtedly enable them to accept more students who would constitute a source of future employees.

When there are positions that persons can fill directly from the school, the examination should be held at a time of year when they can qualify and be available. The advice of the schools in the formulation of examination requirements is valuable.

Approach to Schools and Civil Service

Not only with the schools is it important for the tax-supported hospital to have good standing, but also with community social agencies in general, to whose attention announcements of examinations may be brought. A good name with the local social agencies encourages people to enter this field of work. When examination requirements are high, they attract a better type of personnel. Better qualified persons are interested only when the agency demands good qualifications of all its social work personnel. The announcement of the examination must reach the type of persons whom the hospital would like to see qualify. If only persons with minimum qualifications apply, then the hospital is partly to blame for not interesting better persons in taking the examination.

Sixth, and most important of all, is the responsibility for interpreting needs to the civil service commission itself. The head of the social

work department must be in touch with those persons in the civil service commission who have the final responsibility for the type of examination announced and who rate the papers.

The United States Civil Service Commission, and it is said the better commissions over the country also, welcome the interest and advice not only of the department concerned but of professional associations in the preparation and rating of examinations. It is important to find out the commission's concepts of the work and keep them advised of accepted professional standards. Sometimes only one item may be changed in an examination at a time. In the next examination announced the weakest requirement can be omitted and a better one substituted.

Rating Candidates for Jobs

Many types of examination are now in use in public hospitals over the country and as yet no authoritative study has been made evaluating them. Some examinations are assembled, others nonassembled, depending on whether the candidate's presence is required in the examination. The latter type may consist of the submission by the candidate of a description of education and experience, corroborated by documentary evidence, and a thesis on a general or specific subject, this to be followed by a personal interview.

Problems arise regarding the amount of emphasis to be placed on good grades in undergraduate and professional school work, in determining the relative credit of a year of school work and a year of supervised employment, in deciding whether the agency in which the experience was gained is approved or in evaluating the quality of supervision given.

A thesis will often help decide a just rating when two candidates' experience as described on paper seems alike. A thesis of 2,000 words not only discourages the poor candidate from applying, but favors the better trained person in that she is likely to have a carefully prepared school paper ready to present. The thesis often shows up the mental calibre of the candidate clearly.

The expression, "or equivalent thereof," may prove a vague and undesirable loophole in connection with educational requirements and experience. It seems better to set certain standards and occasionally lose a superior person than throw the gates wide open through the word "equivalent." A physical examination and residence in the state for a year are sometimes required. Residence requirements are to be avoided if possible, as they limit the supply of good candidates. In preparing an assembled examination advice

may be needed in the preparation of questions to be answered, as true or false, or by selection of a multiple choice of answers or by completion of sentences. Case situations are sometimes stated and the candidate is asked to analyze the problem and plan adequate treatment. Candidates are sometimes asked to state the functions of the various social agencies in the community, or to state the rules regarding legal eligibility of patients to admission to the hospital. Whether a candidate knows the answers to these two types of question is not important, because the answers to such questions could surely be learned within a few weeks on the job.

Some examinations require an oral interview and the commission invites advice as to points to be considered. For example, the rating may be based on age, personal appearance, physical health and defects, manner of approach and evidence of interest in the general field of social work and in the specific type of work under consideration. Another problem may be the relative weight to be given education and experience and the written and oral tests.

A commission may be willing to have two groups of requirements with persons qualifying under the higher group certified first. When the register of eligibles has been established, some commissions require the selection of one from the three candidates with the highest ratings. The department then has the privilege of raising objections if it seems the candidate was wrongly admitted to the examination.

A second factor in securing adequate personnel is squarely the concern of the hospital itself: careful attention to the candidate during the probationary period, whether it is three, six or twelve months. This period should be considered really a part of the examination. The twelve months' period provides a more satisfactory time in which to evaluate the progress and potentiality of the candidate. It also gives opportunity to see whether the candidate is able to profit from supervision and frank efforts to guide her work.

Public hospitals sometimes have the reputation of being unable to rid themselves of dead wood. The blame usually rests upon the person who permitted an unsatisfactory probationer to become a permanent employee. Resignations from private agencies, however, are sometimes difficult to effect, but in either case they often can be accomplished through a frank discussion with the employee. The preferring of substantiated charges is a last resort. The retirement system is useful in instances in which physical or mental disability exists.

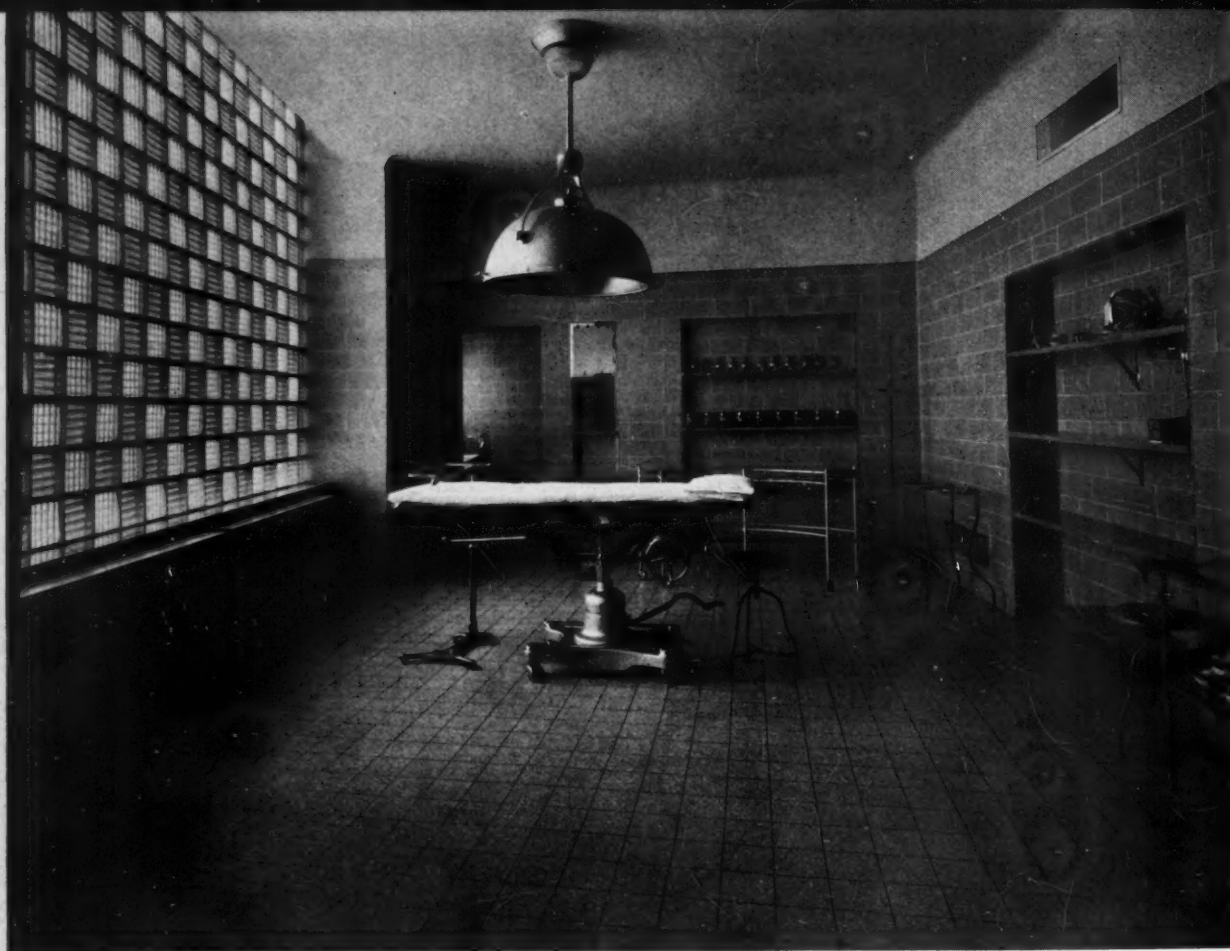
Other considerations in the obtaining of person-



This panel is a part of the social service publicity program of a voluntary hospital—Children's Memorial, Chicago. Its own staff and the public saw this graphic portrayal of an actual case on National Hospital Day when hundreds of visitors were received.

nel in tax-supported hospitals in the absence of civil service are: (1) the use of the state civil service facilities by local units; (2) a voluntary method under which a committee of persons of indisputable standing, including professional social workers, establishes requirements and passes upon applicants, and (3) constant effort in co-ordination with allied professions and other public spirited groups to get a civil service system established.

The employees of eleven states are now under civil service: Arkansas, California, Colorado, Illinois, Maryland, Massachusetts, New Jersey, New York, Ohio, Tennessee and Wisconsin. Kentucky passed a civil service law in 1936. Civil service bills have been introduced in Connecticut, Georgia, Indiana, Michigan and Minnesota, and are being prepared in Idaho, Maine and Nebraska. This rapid extension of the merit system is a most hopeful augury for the standard of social work personnel in tax-supported hospitals.



Operating Room, New Style

By FLORENCE H. HICKOK, R.N.

A SPECIALLY constructed glass window, a new type of air filter and equipment flush with the walls are notable features of the new operating unit completed recently in Cohoes Hospital at Cohoes, N. Y. Cost of the new unit was \$25,000.

This structure, into which the latest type of material has been placed, measures 40 by 30 feet. In addition several sections of the original building adjoining the new unit have been modernized.

A window, 13 by 9 feet, made of glass blocks is located along the western wall of the new room, providing natural lighting. The thick glass blocks are of the latest type, joined together in the center by weather stripping. Although admitting light, the blocks will prevent bright sunlight from entering the room. More than 100 of these blocks were used in constructing the window. There is a vacuum between the two layers of glass of each block, neutralizing temperature and making the room warmer in winter and cooler in summer. These blocks were purchased and installed at a cost of \$2.50 each.

Located along the same side of the room are two closets, one at each end, for the storing of supplies necessary to the operating room. Provision has been made for both of these closets to be equipped with a new type of air filter window. With this equipment installed, this entire section will be ventilated by having the air withdrawn from the room, washed, purified and returned.

A scrub-up room for physicians, located in an annex off the north side of the operating room, also is equipped with air filter windows. It contains two sinks with the latest drop type hydrants. The water supply is controlled by a lever knee-high on the sinks.

A lighted recess has been provided in the main operating room in which x-ray pictures may be placed to guide surgeons while operating. A new sterilizing room has been constructed off the south end of the structure, connected with the new operating room. Sterilizing tanks are flush with the

wall surface. Operating levers and gauges are located along the wall. Sterilizing is done by a gas controlled switch. When ready to sterilize a switch is turned on in the sterilizing room and instantly steam generates to pipes around the tank. This has proved both economical and time saving. One of the main features of the operating room is a shadowless light that drops from the center. For operating purposes it has three degrees of light. This was a gift of the ladies' auxiliary.

The structure is fireproof throughout. Flooring is of special terrazzo with metal ground strips. These strips will eliminate danger of explosion during summer storms. The walls, 9 feet high, are of high quality tiling, soft gray in color. All wiring and motors used in the new section of the building are sparkproof to prevent the possibility of explosion when ether is being used. The lights in the operating room and other sections of the new addition are also connected with storage batteries, to provide lighting in the event regular power is cut off.

The old dressing room for surgeons, located in the hospital proper, has been completely remodeled into a modern locker room. This is now

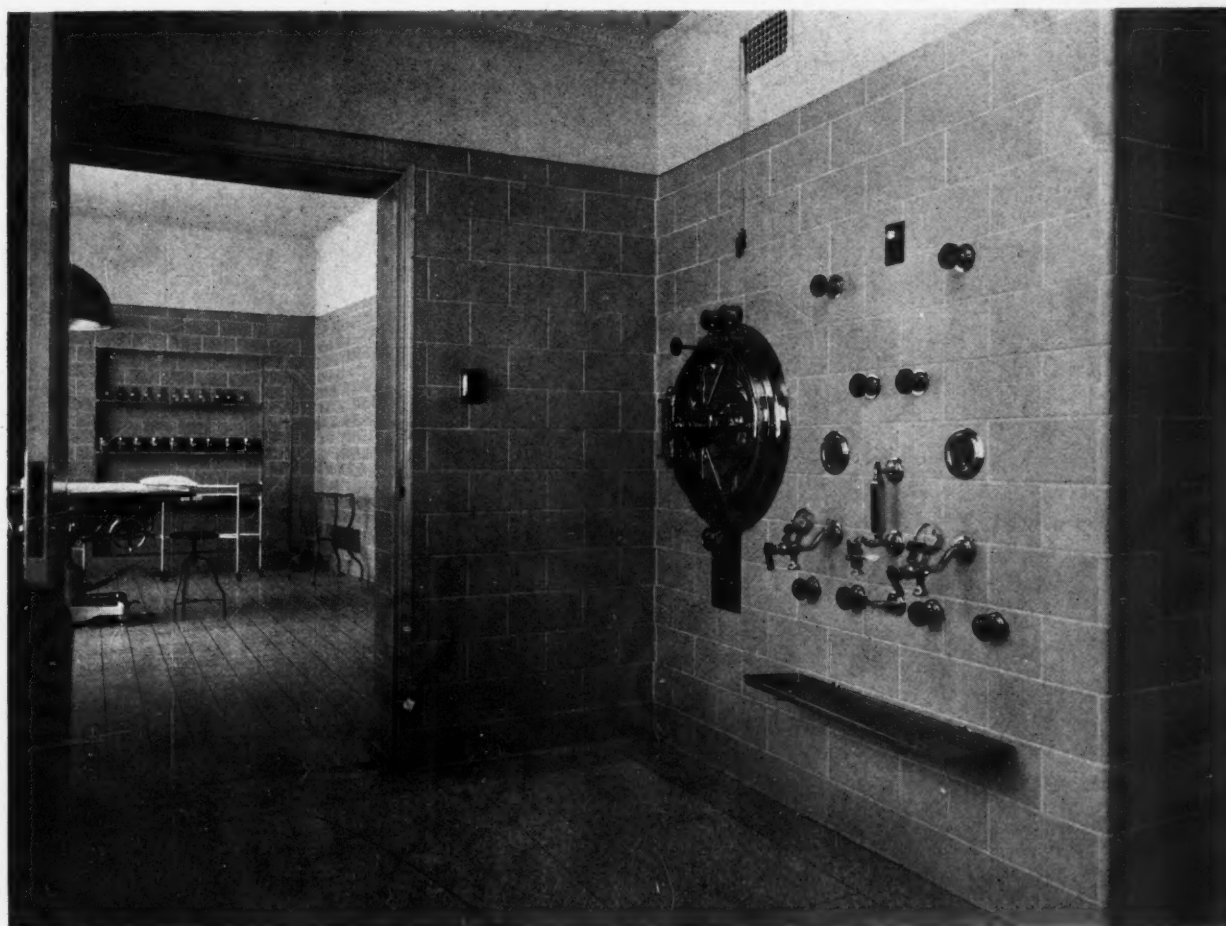
equipped with showers and with fifteen lockers.

Six instrument cabinets have been installed in an adjoining room connected by a corridor. These provide individual instrument storage for the various surgeons. The cabinets are equipped with glass shelves and a light at the top of each cabinet provides illumination through to the bottom shelf. The old unit adjoining has been remodeled to provide a modern emergency room and a second operating room. The color scheme and plan of the new room have been carried out in the old section.

The hospital is now supplied with its own distilled water through the installation of a tank for its manufacture. Distilled water is piped through to the new sterilizing room.

On Jan. 17, 1937, the new unit was opened for public inspection. Between 400 and 500 persons visited the hospital at that time. The ladies' auxiliary served tea and members of the board of directors, assisted by the nursing staff, escorted guests through the hospital.

The public was again invited to visit the new unit on National Hospital Day, May 12, when the new room was set up as for a bona fide operation.



Connected with the new operating room at Cohoes is a sterilizing room. Tanks are flush with the wall, and operating levers and gauges make a symmetrical pattern. Opposite is a view of the operating room.

Bedside or Shop

By ARSHALOUS KASABACH



Enter, above, the eighth floor shop at the University of Michigan Hospital, where up-patients from all floors come to work. At the left, the instructor comes to the bedside, there to help one patient with the Swedish weaving of a scarf, while his ward mate makes use of the library service.

On the opposite page, left, is the bulletin board project as it appeared one month recently. To the right, another view of the acute ward. One young man makes and sells leather belts, some of which may be seen displayed on his traction frame.



OCCUPATIONAL therapy as an organized program was introduced into the University Hospital, University of Michigan, in 1922 with one worker, although some random and constructive work had been done previously. The department has since then grown, both in personnel and activities, along various craft lines as well as in fine arts and social studies. Students have received instruction and increases have been made in the staff as resources permitted and the hospital expanded.

By 1929 the number of patients had increased to a point where it seemed advisable to define further the interests of adults and children, children under thirteen being assigned to the department of special education with a distinct educational program while those twelve years of age and over were assigned to the occupational therapy department, where occupational, educational, prevocational and diversional interests are developed.

Activities within the department are inter-related. This permits the special education, hospi-

tal school, library service and occupational therapy to function together along similar lines, supplementing initial interests within the patient's estimated need and encouraging a redefinition of activities.

A boy of fourteen has school instruction in the morning, receiving academic work; then he has occupational therapy for new interests after which he may read for a time, collecting material from available books. The roof offers recreational activities and participation in outside fresh air games. The day for such a patient, while entailing treatment intervals, does offer association with others, opportunity for constructive experiences and expression of energy, with absorption of new interests and diversions.

The library service has supplied books, pamphlets, magazines, pictures and information about the lines of work carried on in the shops or on the wards to demonstrate the significance of an activity to the individual and its wider community development. The products showing special skill and interesting color combinations are gratifying.

To strengthen further that which has been started, the occupational therapist encourages patients in their reading and school work, utilizing handwork as a means of education and expression. Handwork can be made an important contribution to patient satisfaction, development and expression in the general hospital through the use of the interest, attention and need for later employment and as a challenge for immediate performance and encouragement.

Reaches 150 Patients Daily

The program for patients is carried on in the three buildings of the hospital as the facilities and the need of patients permit. The main building has a capacity of more than 800 acute cases. Occupational therapy reaches an average of 150 patients daily through the shop on the eighth floor and the preparation work rooms on the third and fifth floors for ward work.

The eighth floor shop is a large, pleasant room for up-patients or wheel chair patients from all floors. They come to pass their time in a different atmosphere from that on the wards. The shop is equipped with looms, sewing machines, jig-saws, carpenter benches and tools, leather and reed tools, rug frames, knitting machines, hoops, hooks, needles, tables, chairs, a gas stove, a sink, cupboards, showcases, bulletin boards, art and craft magazines, instruction books, patterns and pictures for the use of patients. It is open from eight in the morning until five in the afternoon, with an average attendance of fifteen to thirty each day, with no time limit.

The type of work varies according to the patient's personality, interest and length of stay in the hospital. Individual requirements are varied. Some accept the idea of occupation eagerly while others require various degrees of attention. Some can have unlimited activity while others need limited or graduated work. Each patient must be guided carefully to secure satisfactory results within the outlined medical program.

Weaving, woodwork, basketry, shoe repairing and rug making are among the basic skills offered. Up-patients are able to do more difficult work. Sewing, embroidery, knotting, knitting, crocheting, painting, designing, block-printing, simple jewelry and leather work are done as desired. Repairing, washing, ironing, finishing of projects, cutting and sewing rags, shellacking, sandpapering, drilling and many other odd bits of work are done by the patients who stay only a short time. Emphasis is placed on the use of familiar materials and methods of work.

Bedside work is carried on in the acute wards throughout the hospital, including all medical

services. The physician writes the "refer," stating the diagnosis and any time or activity restriction. The patient needs the work, but the approach and the project to be given are difficult to determine. Each one has individual differences to be adjusted according to his need and time. The chief beneficial results of motion of any proper kind may aid in development while overuse, hard work, improper adaption and fatigue actually do harm. Therefore careful observation and direction are necessary to determine whether the chosen work is effective or not, is too hard or too easy, is too long or too short, or improperly adapted to the patient.

Medical patients on the second floor enjoy light work, but need less stimulating or modified activity, with more instruction and supervision to challenge and direct their interest.

The third floor houses men patients of all ages on bone and joint and surgery services. They are difficult to interest in light crafts suitable for bed projects. They would rather get their hands on a good hammer and nails, not realizing that their strength is limited. A vibrating saw, which could be taken from bed to bed, served the purpose for awhile. The younger ones sawed the wood and the others sandpapered, glued and painted many attractive articles.

Ingenuity Often Shown

One of the boys wanted to do some inlay work on his tray base. The fact that he did not have the necessary facilities did not put an end to his efforts. He conceived the idea of cutting a narrow edge on his design lines and by staining the various parts of his design in different values, he produced the effect of inlay. This opened a whole new field for other patients in designing and decorating.

The fourth floor has women and girls on bone and joint, surgery, gynecology and urology services. They are active and busy with knitting, crocheting and sewing.

On the fifth floor are ophthalmology, otology, neurology and dermatology patients. Neurology patients are difficult to approach and need a definite technique. The work is purely occupational, to divert their interests, and sometimes social or recreational. There are a number of children on this floor who remain for short times and are given light work, toys and games.

On the seventh and eighth floors are tuberculous patients, who remain for longer periods of time. They are referred to the occupational therapist by the doctor for designated periods. Their muscular movements are delimited to help the healing process. There was a distinct increase in

the number of patients on these floors, referred during the fiscal year, and the daily attendance averaged from twenty to thirty.

Simpson Memorial Hospital is a small research unit, with a bed capacity of nine patients with anemia, for whom occupational therapy is provided. Every patient is given work unless, according to the physician, he is too ill to carry on a program.

The Convalescent Hospital is a unit in which many types of patients are seen: long-time cases, patients on frames, those who go daily to the main unit for treatment, acutely ill patients, short-time cases, postoperative patients who must remain in the unit for a few days before going home, and others. For the individual the day may be full of griefs. The absorption of time, energy and interest along constructive channels is important.

The occupational therapy unit occupies a building adjacent to the convalescent unit connected by an open archway. Here the patients forget their physical and mental pains while carrying on their activities. Emphasis upon familiar surroundings and projects, even in uncertain and somewhat strained circumstances, gives courage. There are pleasant rooms in this place. There are a playroom for the children, two small offices for the special education teachers, with occupational therapy shops containing basketry materials, tools, looms, an old sewing machine, cobbler's lasts, quilting frames, a work bench with carpenter tools, a jig saw and two radios. Bed patients are cared for in the morning and shop patients in the afternoon, with preparation at intervals as necessary.

Shop Is Gay Place

The shop is open daily from 1 until 4 o'clock in the afternoon. Those able to come, whether in wheel chairs, on crutches or walking, young and old, crowd for entrance. The atmosphere is happy and friendly and the looms bang away while the radios are on. A boy of fourteen is showing an old lady how to start a basket. She in turn will help some one with a French seam. In the wood-work room, the jig saw is whirring, while a boy may play the guitar and sing. Some one in the shop hears him and he is asked to come out where all may hear. Another boy gets a banjo and still another a violin. What fun! How care free! Sick bodies but healthy minds. The shop means to them a place for mutual exchange and friendly interests.

These patients both in bed and in the shop do nearly everything that hand can make. Projects most frequently finished are: belts, baskets, reed lamps, purses, billfolds, cigarette cases, cut-work towels, Swedish weaving and appliqués on linen

towels, aprons, luncheon sets, pot holders, stuffed toys, doll clothes, rug runners and wooden toys.

Exhibitions and sales of finished articles are held on the eighth floor in the main shop. Visitors, hospital employees and patients are encouraged to visit the shop. The patients make three articles and receive one, or pay for the material at cost and retain their own work. The returns from articles sold are utilized to obtain more materials during the year.

A bulletin board has been introduced into the shop for the benefit of the patients in displaying their work, and to give new ideas with supplementary information. A new project is displayed each month.

One of these was the silkworm project. A small glass case back of the bulletin board gave the effect of a little silk factory. Both children and adults interestedly watched the eggs hatch, the worms eat and grow, spin and then lock themselves into cocoons, and after ten days moths come out and lay eggs and then die. Some of the silk was spun and woven into a small wall decoration. Many of the patients and visitors took worms home with them to show their children.

Some Keep on Indefinitely

After patients leave the hospital they are still interested in the projects started. More than 250 individuals, wishing further instruction at home in their spare time, are making part of their living expenses by the sale of gifts or novelties. They take home with them patterns, designs, samples, directions and materials, and each time they return to the clinic, they go to the occupational therapy shop to get new ideas and report progress. Many requests are made by mail for more materials, directions, addresses, information and suggestions.

Special requests have been made by Ann Arbor agencies for the consideration and instruction of selected patients whose day seems long and difficult. A former patient, blind as a result of a brain tumor, comes to the shop weekly, makes baskets, and is learning to knit, thus enabling her to assist in providing clothing for the children.

The work varies according to the patient. Short-time cases make simple, attractive objects, while those who stay longer engage in projects offered as possible future occupations.

At all times playing cards, puzzles, checkers, books, magazines and comic supplements are available to the patients. During the winter months they enjoy movies. These are shown on Wednesday nights in the Convalescent Hospital playroom, and Friday nights at the Main Hospital in the eighth floor shop with a large attendance.

A Surgical Mandate

Cleveland Hospital Council adopts regulations to safeguard patients of member institutions from unqualified practitioners of surgery. This is the council's first mandatory step

FOR the first time in its history the Cleveland Hospital Council has adopted mandatory regulations upon its member hospitals. To safeguard surgical patients, a committee under the chairmanship of Dr. George E. Follansbee, president of the council, prepared the following minimum standards of qualification to practice major surgery:

1. Membership in a recognized local organization of doctors of medicine, the membership of which includes practitioners of both general medicine and the specialties and which has state and national affiliations.

2. Either, (a) two full years of hospital training, at least one of which shall have been in general surgery in a hospital approved for the training of surgical residents by the American Medical Association (in the case of surgical specialties the training shall have been in a hospital approved for such special resident training by the A. M. A.); or (b) membership on the active visiting surgical staff of a member hospital of the Cleveland Hospital Council and classified to do major surgery; or (c) fellowship in the American College of Surgeons, or (d) not qualifying as above but having had sufficient surgical experience, when certified by a member hospital of the Cleveland Hospital Council that has adopted these minimum standards, and on recommendation of the surgical authority of that hospital, accompanied by a statement of experience and training justifying the recommendation.

Major Surgery Defined

The committee believes that the staff as a whole or its designated representatives is the authority best qualified to judge applicants.

For the purpose of establishing the minimum

standards, "major surgery" has been defined as:

1. Operations within or upon the contents of the following cavities: cranium, thorax and abdomen, including the pelvis.

2. Other operations which, because of locality, condition of the patient, difficulty or length of time required to operate, constitute a distinct hazard to life.

3. In case of doubt or dispute, the surgical authority of the interested hospital shall determine whether an operation is major or minor.

The committee recommended that these new regulations should not be retroactive but be put into effect Nov. 1, 1936, and should govern all applicants from that date.

The committee further recommended that the classification of member hospitals be restricted to those hospitals which meet present requirements and agree to adopt and maintain recommended standards for the practice of major surgery.

Approval Is Not Transferable

In promulgating the standards, the committee stressed the fact that the standards were minimal and that any hospital could establish for itself a higher standard but no hospital "agreeing to co-operate may establish a lower standard."

The committee also stated that "an applicant having been approved to practice major surgery in a certain hospital has no right because of such approval to demand permission to practice major surgery in another hospital, whether with a higher or a lower standard. No hospital is obligated to accept an applicant because of the fact that he has qualifications herein set forth, but each hospital shall be its own judge within the restrictions herein set forth. Classification to practice major surgery in a hospital is revocable at any time at the discretion of the surgical authority of that hospital."

The council hopes, by these measures, to afford reasonable protection of patients against inefficient and inadvisable operation, to protect the reputation of the hospitals and to elevate the practice of major surgery.

Scene II: Medical Ward

By JOSEPH C. DOANE, M.D.

LAST month the duties, qualifications and relationships of the supervising nurse of the surgical division of the hospital were discussed. It was shown that she is the cog that makes or breaks efficiency in the department under her charge.

Similarly the medical supervising nurse serves as a contact officer between her department and each of many hospital units. She is, first of all, the administrator of a ward or wards containing a large group of patients. She is capable of establishing a high morale among those of the nursing group assigned to her and the resident physician staff working in her department. By lack of poise, tact and understanding, on the other hand, she may create situations characterized by the entrance of personalities and inefficiency.

Inherent in a skillful departmental supervisor must be those qualities that characterize a good hospital administrator. An understanding of human nature to the extent of recognizing the strain under which patients and relatives are laboring is essential, as well as diplomacy in settling difficulties arising between interns and nurses. She must in many instances be capable of serving not only as the scientific but also as the domestic supervisor of a large hospital area. Her attitude must differ from that of the surgical supervisor in that there is less of the dramatic and more drudgery in the treatment of medical patients.

Extra-Nursing Duties

Because of the great variation in the severity and infectiousness of the diseases that pass through the medical ward of a hospital, little routine can be established in treatment. Moreover, the difficulties of diagnosis cannot be looked upon as trivial. While it is possible to lay down preoperative and postoperative routines in the surgical department, this principle is only slightly applicable in the case of the medical patient. Probably in a medical ward more than elsewhere there are duties assigned to nurses that lie outside

One month later. The action shifts from the surgical ward to the medical ward. The supervising nurse once again plays the stellar rôle

actual nursing care. These include the growing tendency for nurses to take and chart blood pressures, to record intake and output figures and to perform other duties which are of assistance to the doctor but which are not always considered as rightfully belonging to the nurse.

Dividing Line Dwindles

Medical nursing, therefore, for those who are not equipped or interested is likely to become tedious, easily destroying nursing morale. Yet the dividing line between medical and surgical conditions is ever narrowing. Arthritis, high blood pressure and other states formerly considered as purely medical now are being attacked by the surgeon, while erysipelas and certain types of chronic infection formerly classed as surgical are treated in the medical ward. A patient may be admitted with pneumonia, pleurisy, heart or kidney disease in which there develops a need for minor surgery such as tapplings, blood-letting and spinal punctures, indicating the close relationship that should exist between these two hospital divisions and the need for cooperation.

The skilled medical supervisor develops an aptness and an ability in recognizing objective symptoms that may escape the untrained eye of the young doctor.

It is the trained nurse supervisor who observing a pulse of fifty which a pupil nurse has charted directs her to return to the bedside to count the pulse at the cardiac apex or at the carotid artery. It is a well known fact that in cases of cardiac irregularity the pulse at the heart may vary from 25 to 50 per cent as compared with that at the wrist. An uninformed, untutored young nurse might infer that a change in pulse

rate from 120 to 70 indicates an improvement in the patient's condition. The trained supervisor at once recognizes that such a charting by a pupil nurse indicates the need for the presence of the physician at the patient's bedside.

The medical supervisor is given responsibility for bedside teaching of pupil nurses to a degree not exceeded by the instructor of nurses in the classroom. This type of teaching is highly important to the future of nursing because more young nurses will be called upon to care for medical patients in the home than in the hospital.

A keen medical supervisor saves the hospital much time and money by avoiding delays in the discharge of the patient because of mistakes in the collection, preparation and transmission of laboratory specimens. If the average stay of the medical patient ranges from eighteen to twenty days, any occurrence that prolongs this stay is highly expensive both to the hospital and to the community.

Collecting Urine Specimens

The first work of the day to come under the supervision of the medical supervisor is the collection and the preparation of urine specimens to be sent to the laboratory. The rules of most hospitals specifically direct that a urinalysis be done each morning for three days on the newly admitted patient and that after this time specimens be collected only upon the written order of the doctor. Often a medical patient averages from ten to fifteen urinalyses a month with no indication therefor, thus increasing the work of the laboratory and the nurse. Sterile or unsterile urine specimens may be asked for. In the former, a catheterization is necessary with the use of a sterile container.

In the collection of a twenty-four-hour specimen, which is a common request in the medical wards, available ice box space and the use of a dram of toluol or a few drops of 40 per cent formaldehyde in a clean gallon bottle are employed to prevent the deterioration of the specimen. When urine becomes alkaline, casts and other tell-tale signs of nephritis are likely to be destroyed. Here the efficiency of the nurse may actually determine the diagnosis of a disease state.

In the so-called renal function test known as the P.S.P. test, or the phenolsulphonphthalein test, the accuracy of the nurse's technique in collecting the specimen may entirely determine the doctor's opinion of kidney ability. In one instance it was observed that a report from the laboratory was returned as 18 per cent elimination of the dye the first hour and 8 per cent the second hour. Since this test depends wholly upon the amount of dye

excreted in a given time, the spilling of urine or the failure of the patient completely to empty his bladder will greatly affect the report returned from the laboratory.

Another mistake that a careless supervising nurse may cause is incorrect labeling of specimens or mixing of specimens. The mixing of sputum specimens, for example, may produce a diagnosis of tuberculosis in a case in which it does not exist, or cause the omission of a correct diagnosis in another. In the instance of cerebrospinal fluid in which the patient has been put to pain and discomfort incident to a spinal tap, a mistake by a careless nurse is almost unforgivable. The proper labeling of the specimen, the correct execution of the request card and the safe transportation of the specimen to the laboratory, all present possibilities of mistakes that directly affect the welfare of the sick.

When infectious material is being transported to the laboratory, as a public health precaution the supervising nurse must see that it is properly labeled. The words "infectious material" are usually written across the request card in red ink.

In some medical departments, cards 6 by 10 inches in size are used, upon which are plainly printed such directions as "no breakfast," "no fluids," "do not turn patient," or "no visitors." If by error a patient is permitted his breakfast before blood for urea, uric acid and creatinin has been collected, the specimen cannot be taken and a day of expense is added to the hospital and to the patient.

In collecting urine for Fischer's concentration test or Mosenthal's test, the success of the study is often dependent upon the nurse's accuracy. If the patient is allowed forbidden fluids or if the urine is spilled or lost the comparison between the day and night urine cannot be made and the whole process is worthless. It is the medical supervisor's duty to impress upon students the necessity for accuracy so that such accidents cannot happen.

Teaching Practical Duties

Certain laboratory activities must be performed at the bedside. The nurse is required to read and chart blood sedimentation curves, and in the case of the diabetic often to perform fractional urinalyses. These procedures must be taught by the medical supervisor.

The ward nurse also is required to watch the progress of hypodermoclyses and enteroclyses. She withdraws fractional gastric specimens at fifteen-minute intervals. She inspects the progress of intravenous drip solutions, never allowing the patient to continue in discomfort when the

solution ceases to run. She should not be permitted to place and probably not to withdraw hypodermoclysis needles. In some hospitals intramuscular injections may not be given by the nurse, and more than 2 c.c. of a solution may not be injected subcutaneously except in the presence of a supervisor, or even of the physician.

Economy and efficiency in dispensing food are largely in the hands of the supervising nurse of the medical department. She is responsible for serving trays, for avoiding the mixing of trays and for saving food by requiring that patients' desires be known before food that cannot be consumed is placed upon a tray. In the case of special diets, she weighs refuse or returns it to the kitchen for this purpose.

Many a skillful supervisor of nurses has wondered why hospital routine requires that breakfast be served to ward patients at 6:15 a.m., lunch at 11:30 a.m., and supper at 4:30 p.m. To awaken a patient at 6:15 a.m. for his breakfast and to give him no food from 4:30 p.m. to 6:15 a.m. is a

relic of a barbarous institutional past. No matter what difficulties are involved, ward patients should be served at 7:30 a.m., 12:30 p.m. and 5:30 p.m., and inter-meal feedings should be provided if necessary, particularly at bedtime.

More drugs are necessary for use in this department than in any other. Drug closets should be orderly, each container having a place where it should remain. The dosage should be indelibly marked upon each bottle. The medical resident physician can assist the supervisor of nurses in working out medication procedures.

Charting by the nurse is of legal importance, because it has been decided that mere ordering of a drug by a doctor does not constitute evidence that it was given, unless its actual administration is noted on the nurse's record.

The supervisor often is overwhelmed during the difficult period of visiting hour. The presence of patients' relatives offers a splendid contact possibility. If ever the supervisor is needed, it is to maintain ward discipline on visiting day.

Looking at Labor Unions

(Continued from page 53)

7. On the fifth, tenth, fifteenth, twentieth or similar anniversary of an employee's association with the hospital he should be granted an extra week of vacation. For the intervening years the employee's vacation should revert to schedule.

8. Split vacations should not be permitted except by special permission and in no event should the vacation be divided into more than two periods.

9. This schedule should rest upon the understanding that the beneficiaries of it shall relieve one another in all periods of individual sick leave and vacations with no assistance from extra personnel or a minimum of such assistance.

Grievance or Conference Committee. Since strikes cannot be tolerated in hospitals, then collective bargaining would be only nominal unless some other method of settling disputes is set up. Each hospital should set up a conference committee to consider any matter that employees desire to discuss with the management or the management may wish to discuss with the employees. This committee should be composed of the administrator, with, perhaps, a trustee, and representatives of employees. These representatives should be elected by the employees and should number about three.

Hire and Discharge. Hospitals should preserve the liberty to employ whomsoever they wish and to discharge or transfer employees as may be deemed best.

Better Personnel Practices. Hospitals have made far too little use of the rapidly growing body of techniques in personnel management. Job analyses and job gradings, the development of equitable salary and vacation schedules, good preventive medical care of employees, the training of employees to perform their work more efficiently and to prepare themselves for advancement to the full limit of their capabilities and the use of adequate personnel records, all are necessary parts of such a program.

I wish at this time to express my appreciation for the splendid cooperation, not only of the participating hospitals, but of the members of the committee on the hospital personnel relations who have given much of their time and effort in the preparation of the report. I wish especially to record my indebtedness to Dr. Arnold F. Emch, executive director of the Chicago Hospital Council, and Alden B. Mills, managing editor of *The MODERN HOSPITAL*, for their expeditious handling of the manifold problems incident to the completion of the survey.

PLANT OPERATION

Conducted by John R. Mannix and R. C. Buerki, M.D.

Visibility: High

By C. E. Ferree and G. Rand

Even small improvements in x-ray films and plates merit attention and are prized by diagnosticians and surgeons

THE usefulness of x-ray plates and films to the surgeon sustains a direct, and to the diagnostician, a proportionate relation to their visibility. Important factors in attaining a high degree of visibility are the brightness and color relationship of the details to the background, and the intensity of the illumination. It may be noted that neutral color details are best seen on a clear white background. With respect to the second factor, it may be said that the amount of light needed to give the highest power to discriminate detail varies with the density of the film and with the person making the examination.

Not all films or all parts of the same film are of the same density; and the intensity of light giving the highest visibility varies widely from person to person, depending upon such factors as age, refractive condition of the eyes, susceptibility to glare, clearness of the media of the eyes and the condition of the sensorium. If too little light is used, low visibility occurs from insufficient stimulation of the retina; if too much, glare and harmful scatter of light are produced. From film to film there is variability in both absorption and scattering action. All these factors lower visibility and confuse the discrimination of detail.

In Figures 1 and 2 is shown a radiograph illuminator devised to satisfy the requirements for high visibility. With it, the intensity of light may be varied in continuous series from zero to full without change in the color or composition of the light or in the size, shape or location of the illuminated area. This variation is accomplished also without any change in the position of the lamp.

The device for producing variable illumination consists of a reflecting housing, which may be of any size or shape desired, a rotating shutter and diffusing element. The last is to break up all shadows and to give evenly distributed and well diffused illumination. It may be seen that the construction can be adapted readily to any size or type of lamp and to cover any range of intensity that might be desired.

The unit consists also of a flaring bonnet-like construction on the front of the housing. Across the opening of the housing just in front of the shutter is a plate of etched Whiterlite glass, which serves to give both color correction and in part the diffusion noted above. Approximately 5 inches in front of this glass and across the opening of the bonnet-like extension is a sheet of Celestialite glass which completes the diffusion and gives a transilluminated background against which the plate or film is viewed.

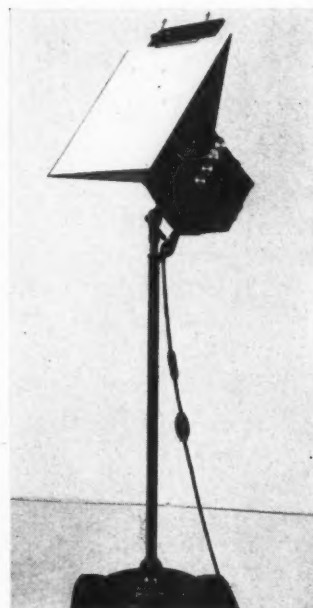
So good is the resulting diffusion that no trace of shadow from the vanes can be seen on this glass. At the top of the extension a clip is added to hold the plate or film in position. For viewing plates or films of different sizes, masks are provided having apertures of various sizes. Daylight glass may be used for the plate directly in front of the shutter, according to the amount of color correction desired. Our experience is that the better the color correction, the better the results. With the diffusion given with this set-up and with sufficient color correction and the proper adjustment of intensity, a greatly improved visibility is obtained.

Good results can be obtained, however, by making both plates of Celestialite glass. This glass affords both an excellent degree of diffusion and some color correction.

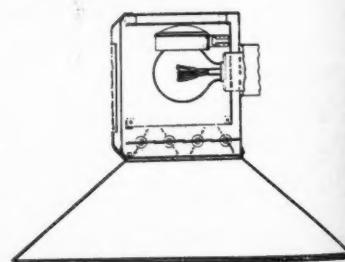
The equipment for varying intensity consists of four vanes which extend across the opening of the housing in such relation to one another that when their flat surfaces are parallel to the beam of light, the maximum amount of light passes through the opening. When they are rotated to a

position at right angles to the beam, the light changes in continuous series from full intensity to zero. In changing the intensity, the vanes are actuated to turn in opposite directions. This ensures an absence of shift in the position of the illuminated area and of change in its size and shape. When all the vanes move in the same direction, as Venetian blinds, all of these changes take place. In the various models of the instrument different means of actuating the vanes have been employed.

In the unit shown in Figure 1, a pin or shank, which passes through an opening to the outside of the housing, is attached to the central point of each end of the vane. Mounted at the outer end of these pins on one side of the unit are cogwheels or gearings, $1\frac{1}{2}$ inches in diameter, which mesh with each other. On one of these cogwheels is a small knob for convenience in turning the vanes. In one of the latest models a simpler means has been devised; this lies within the housing and is entirely free from slack or backlash. It is in the form of a thin plate with a central longitudinal slot through which pass the axle pins



1



2

Fig. 1—A radiograph illuminator provided with variable intensity of light, corrected for color.

Fig. 2—A vertical section of the radiograph illuminator showing the shutter for varying light intensity.

at the ends of the vanes. This slot permits the plate to travel back and forth as the vanes turn. Above and below it in alternate sequence are short vertical slots which engage pins suitably positioned at the ends of the vanes. To the end of the axle of one of the vanes is attached a knob. When this knob is turned, the contiguous vanes rotate in opposite directions as is desired.

When there is need to vary intensity of light, it is the tendency among manufacturers, for purely commercial reasons, to use a rheostat. There are many objections to using a rheostat to vary intensity of light, particularly in the present case. In fact, the mechanical means described above was devised to eliminate these features. The correct use of a rheostat in relation to a source of light, in conjunction with an ammeter or a voltmeter, is to guard against variations in the intensity of light, not to produce them.

Several years of hospital experience have led us to believe that high visibility in radiographs is greatly prized by surgeons and diagnosticians and that even small improvements in this direction merit consideration. We would emphasize the need of having the right amount of light on the radiograph, and the impossibility of getting this amount for different radiographs and different parts of the same radiograph unless the change of intensity can be accomplished in continuous series. This could not well be done, for example, with a rheostat. The difference between the most favorable intensity and the intensity that gives either simple or veiling glare or both is in some cases and for some individuals small.

In this connection we would call to mind the wide range of variation between individuals in the amount of light most favorable for the discrimination of details, and in the difference between this amount and the threshold of glare. In both of these respects age is a most important factor. In general, in the adaptation of intensity to the needs of the individual the difference in the requirements of those under and those above forty years of age is astonishingly great. Differences in the scattering action of the film also creates a need for a means of varying intensity of light in a continuous series or by small steps.

We would strongly emphasize that the change of intensity should not add color to the background against which the details of the radiograph must be viewed. Both the film and the light are already too colored.

Details neutral as to color cannot be seen clearly since their outline blurs against a colored background, particularly when that color is produced by transillumination. The use of a rheostat, for example, would normally mean that the lamp would be run at a reduced voltage, which would cause

a change in color toward the long wave lengths. This change of color might in some cases offset almost, if not entirely, the benefit obtained from change of intensity. The transmitted light is already too yellow. Its further change toward orange by the use of a rheostat is bad indeed. In addition, change in the composition of light changes the amount of scatter given to the light in passing through the film. The long wave lengths are scattered more than the short.

In any attempt to improve the visibility of details in the radiograph, color correction of the light is the initial step.

The ideal condition, therefore, is to start with light of daylight quality and to vary the intensity by just the right amount to give highest possible visibility without changing the color and composition of the light. The full effect of the benefit so obtained must be experienced to be believed. In our opinion no surgeon or diagnostician who has had the opportunity of experiencing these benefits would fail to commend them or hesitate to incur the additional expense of obtaining them. The expense of the device for varying intensity is slight in the simplified form. Properly designed, this equipment may well render a much needed service.

In any event where human welfare and even human life are at stake, small differences in cost are of little

consequence. Our motive for devising this improvement has been the experience of an important need.

The model shown in Figure 1 was not made to suit a particular situation. It was constructed solely for the purpose of trying out the improvement in visibility. But even in the form shown it might be convenient for use in an operating room where the surgeon needs to look at the film while the operation is in progress. The device as described can be adapted readily to any type of stand or cabinet for the examination and study of radiographs.

Made after a suitable design, the equipment serves an excellent purpose for viewing dental films and lantern slides. Made in small sizes, a single rotating vane would suffice for the intensity control. In suitable designs and sizes, a magnifying element can also be used either mounted on the instrument or held in the hand. In addition to its service for viewing x-ray films and plates, we have derived great satisfaction from using the unit in conjunction with a magnifier for studying lantern slides in preparation for lectures and other purposes. Because of the grain of the film, there is, of course, a limitation to the magnification that can be used to advantage. In a magnifying system it may also be noted that a means of varying intensity to suit the degree of magnification is an advantage.

When the Power Fails

ALL hospitals should provide some form of emergency lighting service, according to the latest "Manual of Hospital Standardization" of the American College of Surgeons.

The extreme complications and tragic possibilities that may result from failure of the lighting system while the operating or delivery rooms or accident dispensary are in use, the manual states, are too obvious to mention. On countless occasions failure to provide adequate protection in this respect has resulted in serious consequences.

The most positive and reliable source of emergency lighting protection, in the opinion of the College, is equipment that may be installed within the building. There are three types of equipment used in hospitals: (1) water wheel generators, (2) gas engine generators and (3) storage batteries.

The water wheel system, as the name implies, being operated by the water supply for the building and dependent on minimum pressure, is subject to failure should there be any emergency reduction of pressure.

The gas engine generator system is advisable in hospitals in which a number of lamps may be carried for a long period of time. When the gas engine generator system is used for this purpose it is advisable also to use a storage battery system to furnish light instantaneously, as the gas engine generator system is subject to possible delays in starting which may occur in the case of any gas engine.

Because of the mechanical nature of the foregoing systems, the manual states, they are practical only in those hospitals in which engineers are in constant attendance.

Storage battery systems are probably most commonly used and give more dependable service in the average hospital; and with the improved engineering service that is now available, they are reliable under practically all circumstances. The installation may be fully automatic, the maintenance cost is low, and the only attention required is the addition of water to the battery cells three or four times a year. This system has the advantage of instantaneous response since it is a source of immedi-

ate electrical energy, and this is a factor of extreme importance when an emergency occurs during an extensive operative procedure.

For hospitals with less than 100 beds, which do not have an extensive surgical service, a low voltage unit (12 volt, fully automatic) to which can be attached portable operating lights, and in some cases major overhead lights, is recommended.

This unit also should have sufficient capacity to furnish light for purposes of general illumination in the operating, sterilizing, anesthesia and delivery rooms and also the emergency dispensary.

For hospitals of more than 100 beds, with their extensive requirements, the College recommends a larger storage battery system which will operate at the same voltage as the normal sup-

ply. Such a system will assure adequate emergency illumination in all of the necessary departments; it is also fully automatic, and operates in conjunction with the general lighting equipment of the institution.

Emergency lighting installations for hospital use should include fully automatic charge and control units approved by the National Board of Fire Underwriters.

Sacral Rest for Small Hospitals

By Wilson Stegeman, M.D.

WITH the increasing number of heavy accidents, and the added emphasis that sacro-iliac disease and low-back pathology have received during the last ten years, the number of body casts applied in the United States grows annually. Despite the influx of population into urban centers many of these casts are still being applied, of necessity, in smaller hospitals, where the use of a fracture table is not available. Sometimes expense is the factor occasioning this omission in equipment, but more often it is because of lack of space in which to store the table between cases.

Many substitutes have been devised for the sacral rest, so essential to the application of a body cast, and without which the fitting of a comfortable and efficient plaster jacket is well-nigh impossible. It is hoped that the improvised apparatus described here may be of service, since it is easily and inexpensively made from available material, requires practically no storage space and is efficient.

Every hospital has in its operating

room a three-legged basin holder. This can be transformed into a serviceable support for a sacral rest by the addition of some iron pieces, easily fashioned by any competent blacksmith. The stand, surmounted by the supporting unit and the sacral plate, replaces the dropped tailpiece of the operating table on the middle portion of which the patient's shoulders rest.

The connecting link between the basin ring and the sacral plate is an iron piece, made from three heavy iron straps joined together at their medial ends. Three outer ends hook

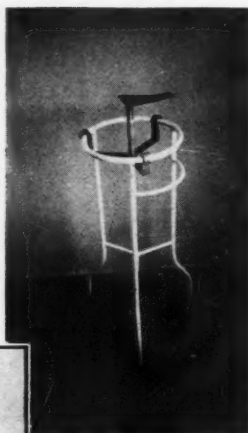
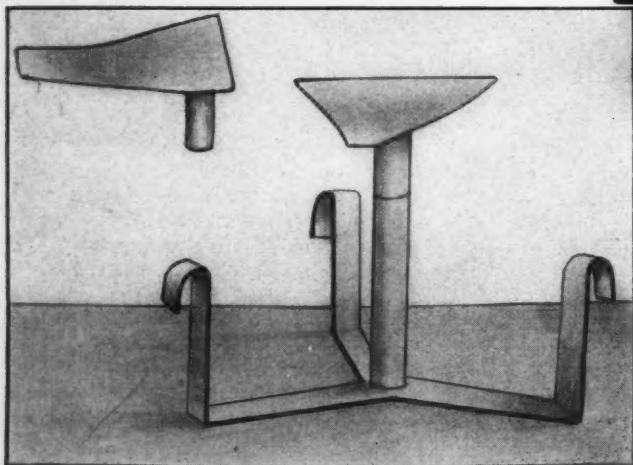
over the ring circle. These ends drop down 6 inches before turning inward at right angles and being joined together at a point from which projects an upright post, one-half inch in diameter, and reaching well past the level of the supporting ring. By having this junction point eccentrically placed in the circle, considerable variation of position of the rest is allowed through merely rotating the supporting piece. Dropping down from the ring lowers the center of gravity of the support and increases the stability of the apparatus.

Around the lower two-thirds of the upright post rests a loosely fitting piece of pipe, to form a shoulder on which rests a similar short piece of pipe brazed to the under side of the sacral plate. This brazed attachment is made near the wider distal end of the triangular sacral rest (cut from sheet steel), thus allowing the application of plaster over most of the plate without hindering its withdrawal.

The hollow stem fits around the upper part of the post and rests on the pipe shoulder below, thus placing the plate high enough to allow the easy passage of hands and plaster beneath the body in applying the cast.

The patient's shoulders are placed on the middle section of the operating table, his hips supported by the sacral rest, which occupies the position of the dropped table end, and his heels are supported distally. The operating table is raised to the suitable height and the cast applied. After the plaster has set, the patient should be lifted slightly, disengaging the plate and stem from the post. The plate is then easily slipped out from under the distal end of the body cast, and the entire light stand and apparatus are lifted out of the way. The table end is now raised or the patient lifted to a cart.

A set of multiplying pulleys, suspended from a strong screw hook in the ceiling and supporting the patient by a canvas sling about his body, is an excellent safety factor in placing and removing the patient, as well as effecting a great saving in the number of helpers required. Its compactness and low cost are especially desirable.



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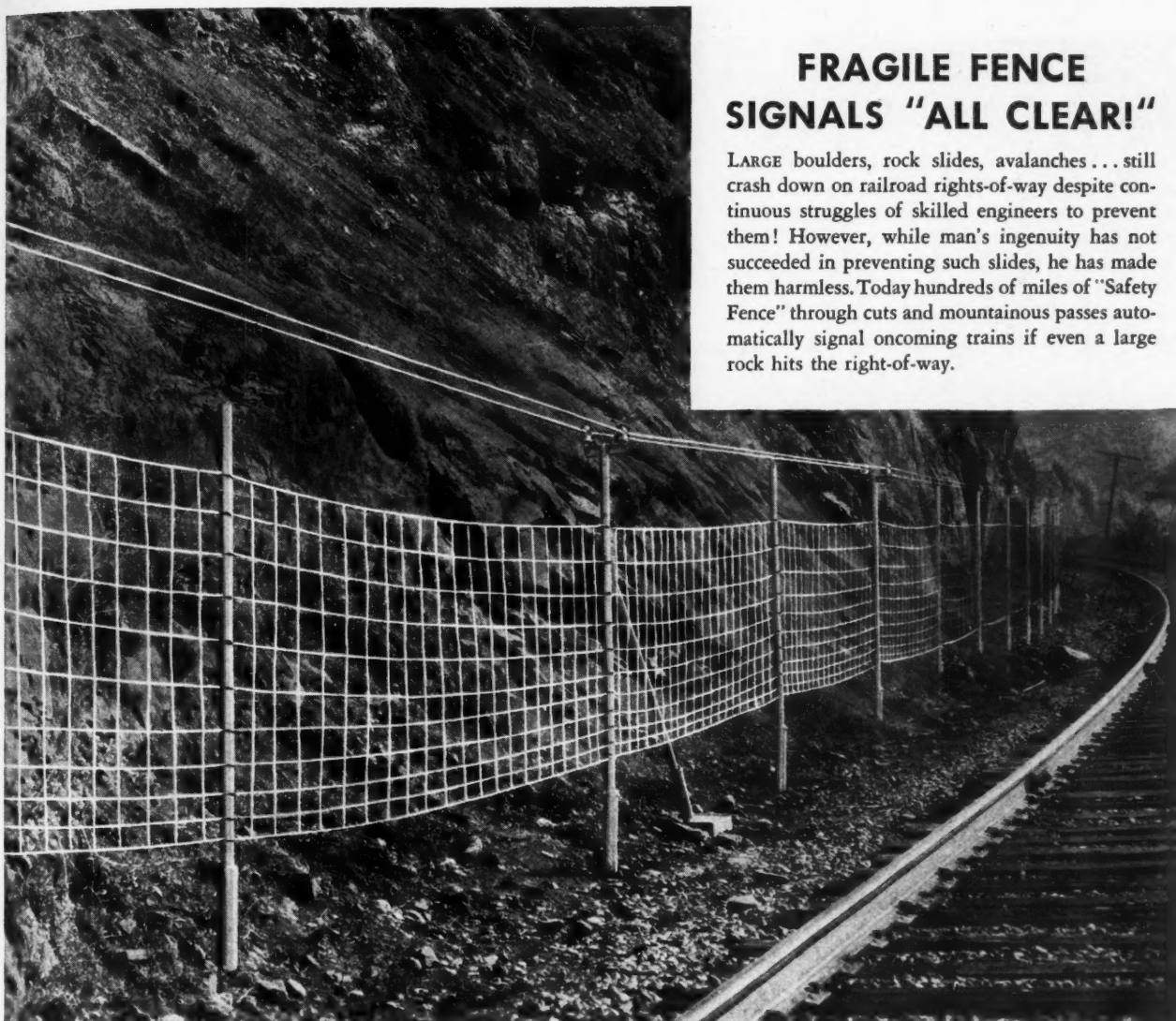
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FRAGILE FENCE SIGNALS "ALL CLEAR!"

LARGE boulders, rock slides, avalanches... still crash down on railroad rights-of-way despite continuous struggles of skilled engineers to prevent them! However, while man's ingenuity has not succeeded in preventing such slides, he has made them harmless. Today hundreds of miles of "Safety Fence" through cuts and mountainous passes automatically signal oncoming trains if even a large rock hits the right-of-way.

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DESPITE perfected equipment and skilled technicians, experience has shown that no solution is safe for intravenous injection until meticulous and all embracing tests have proven it so.

Of course, skilled hands, masters of intricate equipment and apparatus, guided by minds trained for years in their own particular branch of science, are responsible for each exacting step in the preparation of dextrose and other solutions in Saftiflasks.

But, *despite* exacting care in production—no Saftiflask can reach your hands until the lot of which it is a part has been *proven safe* by rigid chemical, bacteriological and physiological tests put on by testing experts entirely divorced from the

production group.

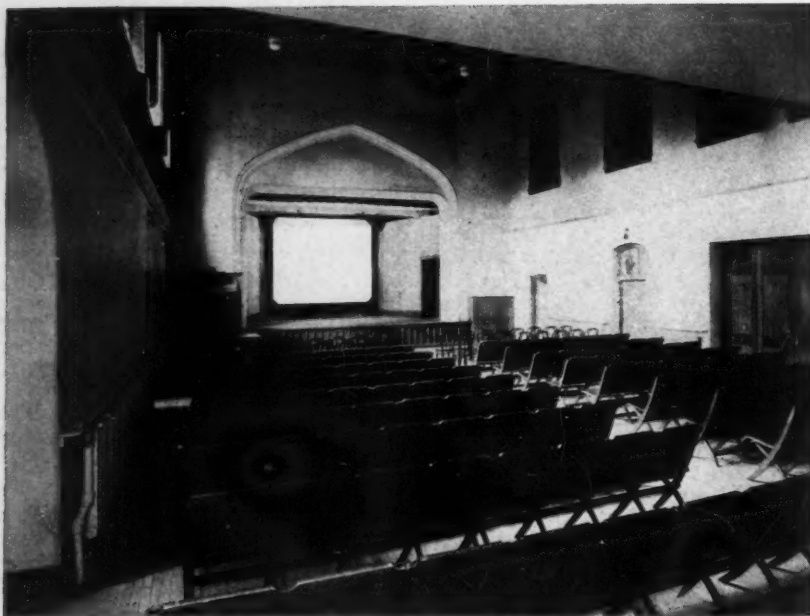
Then, as a final precaution—to give you visible assurance that the solution has not been accidentally exposed to contamination—every Saftiflask is doubly safety-sealed; by vacuum, and by an easily removed viscous seal.

And what do you pay for this assurance that every possible care has been taken to make your dextrose solutions safe? Actually, on the basis of direct costs alone, these ready-to-use solutions in Saftiflasks are less costly than those prepared from concentrated ampules. And, when all of the indirect costs are carefully evaluated, they will be found to be no more costly than those prepared from raw chemicals.

Saftiflasks are available from strategically located distributors throughout the country. They are manufactured by The Cutter Laboratories (U.S. Gov't. License No. 8) of Berkeley, California and 111 No. Canal Street, Chicago. Member of Hospital Exhibitors Association.



Saftiflasks



Where mental patients at Butler Hospital attend sound movies.

Installing Sound Movies

By Francis C. Houghton

THANKS to the generosity of a friend, Butler Hospital, Providence, R. I., a private institution for the care and treatment of mentally ill patients, has recently become able to provide motion pictures for the entertainment of its patients.

Fortunately, there was an auditorium at Butler sufficient in size for our purposes. With the auditorium at hand it remained for us to select a screen and projecting and sound equipment, to construct a projection booth, to wire the booth and to take care of the auditorium's acoustical defects.

Selecting a screen was easy. We had a distance of 65 feet from projector to screen location. Any manufacturer of motion picture equipment will gladly give information regarding the sizes of picture that can be projected in a given "length of throw." There was a choice of two types of screen, one the perforated sound screen; the other the solid screen, both of which come with mat white, silver or beaded finishes.

If the sound screen is used, the speaker can be placed behind it, thus heightening the illusion of sound issuing directly from its proper source. If one of the solid types is used the picture will be sharper and cleaner, but the speaker has to be placed to one side or below the screen, thus lessening the sound illusion. A perforated sound screen 10 by 10 feet, with mat white finish was selected as best fitting our needs.

In selecting the projecting and sound apparatus several factors had to be considered. The important ones were permanency of installation, simplicity of operation, available operators, service and cost.

Portable sound on film 35-mm. equipment was selected. Our projection booth and general set-up is of a permanent type. The equipment chosen, although called portable, is

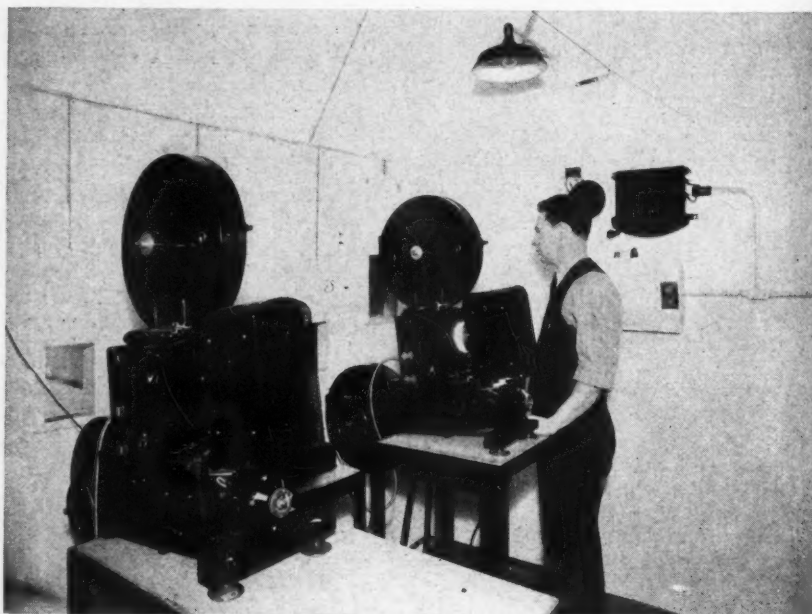
more solid and durable than that ordinarily referred to as such and is easily converted into a permanent arrangement. Owing to a lack of skilled operators among our employees and the rigid city laws for operators of complicated equipment, it was decided to use machines with an electric bulb rather than the carbon arc light. With this equipment it was possible to train operators from our present staff in a few hours and to obtain licenses for them. This would have been much more difficult if carbon arc machines had been chosen.

The machines are so constructed that practically no service is necessary for good operation. An agent in the city is equipped to service if necessary. As cost had to be considered, an effort was made to secure adequate equipment with the money available. Plans for installation included two projectors, thus providing for a continuous running show, and the equipment can handle 2,000-foot reels.

In the construction of a projection booth two things were important: (1) whether or not to build it ourselves, and (2) a careful consideration of the city laws regarding such construction. With an ample force of skilled employees, we decided to do our own work. A copy of the laws was obtained and followed throughout.

Walls, floor and ceiling are constructed of layers of noncombustible wall board and asbestos lumber over 2 by 3 wooden studs. One fusible link will close the four ports in case of fire. The intake and exhaust flues are constructed of metal and are carried directly through the roof of the building. The air is exhausted by means of a variable speed fan. Machines, fire extinguishers and the booth itself have all been inspected and approved.

What has been said regarding booth



The projection booth is staffed from the hospital's own personnel.

New CLEANLINESS and BEAUTY for HOSPITAL WALLS

GOODYEAR Wingfoot WALL RUBBER now enables hospitals to match the cleanliness, durability and beauty of their Goodyear Rubber Floors with walls that have these same proved advantages of rubber.

This newest Goodyear product is the direct result of the matchless skill and experience gained by the world's largest rubber development laboratories.

For complete information regarding the application of Goodyear Wingfoot WALL RUBBER to hospital purposes, write Goodyear, Akron, Ohio — or Los Angeles, California.



Advantages of GOODYEAR WINGFOOT WALL RUBBER

- **BEAUTY**—choice of rich colors and combinations, harmonizing with any decorative scheme.
- **DURABILITY and CLEANLINESS**—smooth, permanent surface easily kept clean and fresh with damp cloth.
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- **APPLICATION**—comes in rolls, one yard wide, 1/16" thick; easy to apply.



THE GREATEST NAME IN RUBBER
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WALL RUBBER

Murals, counter facing, table-tops and wainscoting in "The Rubber Room", Portage Hotel, Akron, Ohio, illustrate effective use of Wingfoot Wall Rubber. Architect: Kenneth C. Welch. Mural Artist: Ivor Johns.

construction is also true of the electrical wiring. The work was done by hospital employees and conforms with the requirements of the electrical code, the fire department and the insurance inspectors.

The matter of acoustics is one to be considered carefully before spending money for treatment. An acoustical engineer was called in when the project was first considered. He recommended treatment which would have cost a considerable sum and which might or might not have given perfect results. However, it was decided to do nothing until some time had been spent with less costly experiments.

Our auditorium is bounded on two sides and at the rear by large rooms shut off by folding doors. At the first showing, these doors were all closed. The results were not good. Before the second showing various schemes were tried, the most effective being merely to open the doors. The results are better, but not perfect. Other possibilities have and will be tried before we will feel justified in having the auditorium treated as was recommended, because of the expense.

The following is a list of approximate costs for the complete installation:

| | |
|--|-------|
| Screen | \$ 50 |
| Projecting and sound equipment | 2,000 |
| Booth, including materials and labor..... | 445 |
| Wiring, including materials and labor..... | 110 |

Patients enjoy the shows immensely. They are eager to learn what is to be shown the following week and express pleasure or disapproval at what they have seen. Normally, one show a week is given including a "short" and one of the best current features obtainable. No fee is charged. A collection box is placed at the door primarily for employees who prefer to attend the shows here rather than to go into the city.

Briefly, it would seem that a hospital with some available funds or good friends could, by carefully balancing or compromising its desires with its limitations, exhibit motion pictures, thereby adding to the pleasure and improving patients' health.

nite changes in the specific forms. It is therefore necessary when the atmosphere is dusty to have a knowledge of the material used, its composition, the quantity of particles in the air and the size of the particle. From the standpoint of harmful inhalation of industrial dusts, particles below ten microns in size are considered significant.

Talc in industry is classified among the important silicates. Exposures to dense clouds of talc dust are common in industry and are implicated in the production of pulmonary diseases, which, however, are of the nondisabling type.

It is always well to remember that both talc and asbestos are hydrous magnesium silicates with many similar chemical and physical properties. Talc can therefore be looked upon with suspicion and so any industry with an excessive talc exposure can ill afford to neglect precautionary measures. The increase in the incidence of respiratory diseases has been linked to exposure to this substance by many investigators.

Measures to control and remove talc dust environment in a hospital are urged. Physical examination of all individuals exposed to this environment is recommended, and chest films should be made. Periodic examinations are also in order. The use of respirators is advised only as a last resort, since engineering control of dusts created by properly designed exhaust hoods and chambers is now possible.

We feel that perhaps many other hospitals in this country are using methods, some more primitive than others, where a potential health hazard is created by the inhalation of the talc dust which contaminates the working atmosphere. The trend of the day, based upon scientific facts and measures, is to prevent and control all dusts, as well as fumes, vapors and gases, since all are dangerous.

Dust Dangers Exposed

By Milton H. Kronenberg, M.D.

IN A laboratory utility workroom of a large city hospital six nurses work an average of fifteen hours a week dusting rubber gloves with talc powder, preparing them for use in the operating rooms and first aid quarters. The size of the room is 12 by 15 by 16 feet, with three windows and one door.

The gloves are placed in a large pan and mixed with the powder, and the excess powder is removed from the glove by slapping it against the hands of the nurse. This procedure creates a dusty environment and contaminates the air. No measures are used to control or remove the dust created and a health problem is thereby caused, similar to that found in the dusty atmosphere of any workshop.

The Division of Industrial Hygiene of the State of Illinois became interested in the matter and a sample of the powder used was obtained and sent to the division's laboratory for chemical analysis. This revealed the following percentages: talc, 82.7; calcium carbonate, 8.7; magnesium carbonate, 7.6; moisture, 1.0.

This analysis was followed up by a study of the air pollution. Using the Impinger method air samples were obtained near the breathing zone of the nurses. Dust counts made showed 39,405,000 particles per cubic foot of

air; 55 per cent of the particles were less than five microns in size. (A micron is 1/25,000 of an inch.) The dark field illumination method was used by the enumerator.

At present dust diseases and dusty environments are much before the public eye and their effects have received a great deal of attention the past few years. The inhalation of dust over a period of years inevitably produces changes in the lungs, as for example, the pigmented lung of the city dweller.

There are many different classifications of dust. However, the list is now becoming reduced, because investigators report that those considered inert nevertheless have caused organic lesions.

Inhaled dust particles, after they have passed through the nose, mouth and trachea and have entered the alveoli of the lung, take on certain activities and produce certain changes in the lung structure, the characteristic one being a fibrosis. There has been an increase in pulmonary diseases in individuals exposed to this hazard. The term in current use for the condition caused is "pneumoconiosis." Specific forms of this term are "silicosis" and "asbestosis."

Certain kinds of dust produce defi-

When Storing Potatoes

If you store potatoes it is wise to follow the suggestions of the Department of Agriculture. This year, the keeping quality of potatoes is low and only high grade potatoes should be stored, for these shrink less in storage than the lower grades. Potatoes should be kept in a temperature of about 60° for the first two weeks. This will heal skin injuries and prevent decay. If French-fried and baked potatoes appear frequently on menus, the storage room temperature should be kept between 50° and 60° after this period. Potatoes that are kept at 40 degrees or lower lose their tastiness and become sweet. Moisture can be controlled by proper ventilation. If the potatoes are kept in large bins, it is a good idea to sort them occasionally.

A NEW NAME HEADED FOR FAME

Goodall Fabrics

will hereafter be called




FABRICS BY GOODALL

A LARGE GROUP OF FABRICS from the famous mills of Goodall-Sanford—widely used in hospitals—have simply been known as "Goodall Fabrics." These flat weaves, plain or printed, have won wide acceptance for their highly satisfactory use as draperies, casements, upholsteries, *non-slip* covers, bedspreads, etc.

But clearly, theirs was not an identifying name, since *all* products of the Goodall Mills might rightfully be called Goodall Fabrics.

And so, to avoid confusion and give these worthy weaves their rightful recognition, we give you a new name and a new signature...

Sanvale Fabrics  *by Goodall*

The present group of Goodall Fabrics successfully used in so many hospitals will of course be found under the new Sanvale name; for a short while, your jobbing or decorating house may show them to you under either name.

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HOUSEKEEPING

Cheer for Children

By Sister M. Benedicta

IT TAKES little to make a healthy child happy. A broomstick becomes a cavorting, bucking bronco with a brave cowboy of seven or eight astride. A demure little miss becomes a fine lady in mother's or big sister's trailing gown, a fan and a pair of high heeled slippers. Even though she does stumble and get all tangled up in her borrowed finery she is a queen or a maid-in-waiting to Queen Mab.

But we are not discussing the well child. Our interest is in the department for the care of the sick child. If it is necessary and important to reassure and orient an adult on his entrance to a hospital, how much more so a child! In what better way can this be accomplished than by the right use of a bright, airy, beautifully decorated children's department, staffed with a scientifically educated and understanding personnel?

A modern pediatric department should plan for wards, private and

semiprivate rooms, open porch, enclosed solarium, nurses' rest room, service room, flower room, utility room and an isolation unit. It should have a desirable location.

Of course a children's department will be noisy at times, either with the cry of the sick child or the squeaks, squeals and happy laughter of the convalescent or the occasional lusty cheer and shout of the brave charioteer in a wheel chair. Therefore it must be away from other patients.

As most hospitals today are built on the block plan and not the cottage plan, it seems fitting that the children's department be placed at the highest point. It must be soundproofed and terrazzo floors are desirable

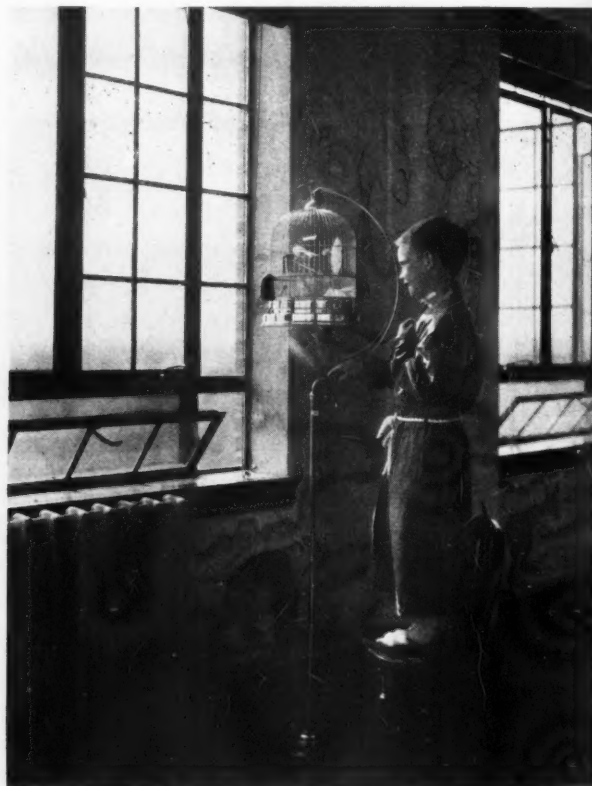
throughout with the exception of the corridors and enclosed solarium. The floors of the corridors and solarium may well be covered with rubber to ensure quiet. Metal doorways, metal and glass cubicles in wards and semiprivate rooms are both sanitary and fireproof.

Sunny wards are best for boys and girls. Surgical and medical cases must be kept separate and a smaller ward must be set apart for babies or feeding cases.

For efficiency and conservation of energy each ward should have running water in a convenient place and a communicating bathroom. Thus it would never be necessary for a nurse to go out into the corridor when in the process of giving nursing care.

The wards should be large enough to accommodate about eight or ten beds. Metal and glass cubicles should form a unit for each child. Windows of clear glass on the corridor side of the wards will enable the children to be visible at all times. Metal lockers are a big factor in keeping order on the wards and also help the nurse to carry out the necessary individual technique.

Private and semiprivate rooms are a necessity in a children's department. Each room should have the accommodation of lavatory with hot and cold running water. Metal and glass cubicles in the semiprivate rooms will



Practicability, simplicity, cheerfulness and convenience, these four must be considered in the children's department. The emphasis in these pictures is placed on cheerfulness.

The Nation's Most Popular Liquid Surgical Soap



Lohador Liquid Surgical Soap is an extra heavy bodied, highly concentrated liquid soap. Prepared from a blend of olive, castor and East India cocoanut oils. Anhydrous soap content of 42-44% enables this product to be diluted as desired. Produced under strict laboratory control and thoroughly aged and filtered which removes any trace of harshness.

Its many satisfied users repeatedly specify Midland Lohador Surgical Soap. Ask about all Midland Hospital Products at booth No. 713-714 at the A. H. A. Convention in Atlantic City, N. J., September 13-17.

Midland

CHEMICAL LABS *Inc.* DUBUQUE IOWA





LITTLE JACK HORNER

Plenty of sun through wide windows, plenty of action in the murals and even good cheer in the floor covering. All of these have therapeutic value, since they keep the children in a happy frame of mind.



LITTLE BO-BOO

give the desired privacy and allow sufficient ventilation without draft.

There should be about four single rooms off the main corridor that can be used for private accommodation or isolation, with a narrow corridor separating the rooms from the main hall. In this private corridor metal lockers, a bath, lavatory, and hot and cold running water would assure perfect isolation for both the patient and nurse.

An open brick porch with a 3-foot enclosure where children in beds and chairs can be wheeled out into the open is most desirable; and an enclosed solarium with wide windows on three sides and a blackboard on the fourth side is almost a necessity.

Personal taste and preference must always play an important rôle in decorating, but four essential points should always be considered, namely, practicability, simplicity, cheerfulness and convenience.

Three principles should always be considered. The first is room exposure. Rooms with southern sunlight suggest cool colors that will absorb the bright rays, such as blue, green and gray. The second consideration is the size of the room. The smaller the room, the lighter the color. Dark colors decrease the size of the room. A spacious, airy atmosphere is essen-

tial. Darkest shades are usually put on the floor and lightest tints on the ceiling. The various shades that range between are used on the furniture and draperies.

Third, the color scheme is important. A dull room may be made sunny; a bright room, restfully cool. Colors that clash may make a nightmarish impression. Light tones such as pale blue, pale yellow, pale green and pale pink are in harmony. Likewise the deeper values of brown, dark gray, blue, green and red will harmonize. Color schemes are simple. They depend on the wise combination of three basic, or primary, colors—red, blue and yellow. Simplicity and cheerfulness should be the dominant notes in the decoration of a children's department.

Let us set up a decorative scheme for a solarium. A warm orange and blue rubber flooring with a center design showing the points of the compass encircled by the alphabet in harmonious colors will give a cheerful and colorful effect. Decorative hand-cut insets, such as Mickey Mouse peeping out of one eye at a sleepy puss and the cow jumping over the moon, will add vivifying atmosphere. On walls, tinted a dawn pink, a circus may be outlined with Jumbo, the elephant,

jumping through a hoop; a clown swinging high in the air; a baby seal balancing a ball, and Brother Bear beating time on a big bass drum. Venetian blinds on the windows are most effective in regulating the light and ventilation.

Furniture of a deep orange color and of appropriate size, including a table with the picture of Little Jack Horner and Miss Muffett on alternate sides, chairs and benches just big enough for little boys and girls, and one or two for grown folk, complete the solarium.

From this inviting and entertaining room we turn our attention to the corridor. Its floor may well be a resilient, noise absorbing rubber, the background of which may be of a gray-pink outlined in black to form a diamond design.

The little girls' ward may be painted in cream and turquoise blue. Tinted walls may depict Cinderella ready for the ball, and her fairy godmother giving her the last warning to be home before midnight.

Esthetic charm may be given the infants' ward with an artistic mural of painted cherubs hovering on dainty wings. A drawing of a guardian angel bending over a sleeping babe creates a much desired spiritual atmosphere.

PROTECTION OF VITAMIN C IN CANNED FOODS

AGAINST ENZYMATIC DESTRUCTION

• One of the unusual features of modern food preservation by canning is the high degree of protection afforded vitamin C during the canning procedure. Of all the vitamins, C is probably the most readily destroyed. Spinach, for example, will lose one-half its vitamin C content upon standing three days at room temperature and practically all of its antiscorbutic potency in seven days' time (1).

Oxidation is the principal factor operating in the destruction of vitamin C. The rate of oxidation depends—among other things—upon temperature, degree of exposure to oxygen, and presence of substances which catalyze the oxidation reaction. Chief among the catalysts is the enzyme known as ascorbic acid oxidase. This enzyme is instrumental in the loss of physiologically active forms of cevitamic acid (ascorbic acid) by catalyzing the transformation of this latter substance into dehydrocevitamic acid (dehydroascorbic acid), which is more readily decomposed by a nonenzymic reaction into a compound having no antiscorbutic activity. This enzyme is apparently widely distributed in the

vegetable kingdom, having been found in cabbage, carrots, lima beans, parsnips, peas, pumpkin, spinach, squash, string beans, sweet corn and swiss chard. Fortunately, the cevitamic acid oxidase is completely inactivated by heating to 100°C. for one minute (2).

In modern canning practice field crops are harvested at the optimum stage of maturity and canned as rapidly as possible—usually within a few hours' time. Early in every canning procedure the product receives either a blanch or a pre-cook or exhaust, the primary purpose of which is to drive out air from biological tissues and to establish a vacuum by expanding the contents of the can by heat, contraction upon cooling resulting in a partial vacuum within the can. These preliminary heat treatments together with the heat process serve both to destroy oxidative enzymes and to remove most of the air from the can.

Thus, the various practices in the canning procedure combine to afford excellent protection for this most labile accessory food factor known as vitamin C.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1936, Food Research, 1, 1

(2) 1936, J. Biol. Chem., 116, 717

This is the twenty-seventh in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

In the boys' ward, if the exposure lends itself to the decorative scheme, Pop Eye, the Sailor, may look down from ivory walls to see if everyone is eating his spinach. Friends such as Huckleberry Finn and Tom Sawyer with his torn straw hat, fishing rod and cheerful grin, make welcome company for sick lads. A nice line of waddling ducks is jolly.

Isolation rooms are better if they are not adorned, as smooth plain walls are best adapted to the cleaning necessary in an isolation unit.

Private rooms, equipped with lavatory and hot and cold running water, can be made enchanting and arrest-

ing if each room is furnished in a different color with a special attraction on the walls either in story form or single features. One room may be in magenta and red with the story of Red Riding Hood on the walls. Another may be furnished in blue with birds and butterflies flying about.

A children's department ideally located, beautifully and artistically decorated and under the supervision of sympathetic, scientifically educated persons is not a luxury or an extravagance. It has therapeutic and moral value. Beautiful surroundings, sunshine and cheer will hasten the recovery of the child.

Facts the Housekeeper Should Know

By Mary E. Sullivan

HOSPITAL housekeeping does not differ in the fundamentals from hotel housekeeping. There are various types of floorings and walls to be washed, windows to be kept clean, metals and woods to be polished. Service, too, is expected. Routine rounds and visitors are to be taken into account. Hospitals may well compete with hotels today when they display their beautiful lobbies, offices and private rooms with gay colors and lovely furnishings.

The housekeeper must know which cleaner is best and most economical to use on each different surface and material, and how it must be used. Two-thirds of a housekeeper's day in a hospital is spent in making rounds, the other third in interviewing and recording.

For wall washing try a good neutral soap on ordinary paints; on oil paint that is badly soiled use a solution of some reliable detergent with mild soap. An effective cleanser for very soiled kitchen walls is a solution made of sal soda—1 cup to two-thirds of a pail of water. This is wiped on quickly with an even stroke upward and as quickly followed with another spongeful of plain hot water used with a downward stroke.

Only a small section of the wall is treated at a time. Sometimes a second application of hot water is used, but always the stroke is light and quick, and as each section is finished, it is lightly polished with a clean cloth. A trustworthy man should do this job because it is hard and tedious work. The brine is merely to soften the grime so that the clean water sponge will remove it. Delay or pressure should be avoided, as either will loosen the paint.

When washing windows during freezing weather window washers

should wear gloves, and should first clean the windows with kerosene or vinegar. Screens also may be cleaned with kerosene, which helps to keep the flies away but does not leave the screen as clean as water will. Kerosene is also fine for cleaning dark metal beds and furniture. However, it has an obnoxious odor, and for this reason a better method for this is to use a cloth wrung out in hot water and then sprinkled with furniture oil.

For cleaning Venetian blinds the housekeeper may have the carpenter make two long narrow fingers of wood, attach them to a stick and pad them. A dusting with this gadget will give pleasing results.

It is a good idea to have a piece of wood with long nails in it in each utility closet to be used for cleaning floor brushes and carpet sweepers.

Use a good detergent when scouring terrazzo floors once a month. Unless very soiled, the daily mopping with clear water will keep such floors looking well. Soap will make them slippery. Alkalies will cause the cement in them to burst, and the marble pieces, of which the floor is composed, will become loose. A poultice of detergent and Javelle water will remove most stains. Use ammonia for iodine; paint fresh silver nitrate stains with iodine and then wash with ammonia. Urine stains are most difficult, since most urines are acid; try an alkali first, but the danger is that it may set the stain. Muriatic acid, carefully applied, may help.

Linoleum is the easiest of all floor coverings to keep clean, I believe. The old way of waxing and polishing with pastes resulted in a lovely looking floor, but that took time and labor which are two scarce things today, so now we have water waxes. Do not make the mistake of waxing too often

or you will have a soft finish that is easily marred. A thin layer of wax, then polish, another layer of wax and polish again, and so on, until a substantial wax coating is built up. Wet dust and polish for routine care. Experiment a little.

The same procedure should be applied to rubber floors, but be sure the wax is an all-purpose wax or one especially prepared for rubber. Rubber tile is expensive and lovely. It may be scrubbed with the machine if the operator is sure to use the least quantity of water practical. Do not hurry this job. After cleaning, build up the coating.

Composition and magnesite floors must be cleaned and then waxed and given the same care as described for rubber floors. In cleaning, be sure to use special preparations sold for such flooring. Wood floors are usually sealed or stained and then the wax is applied.

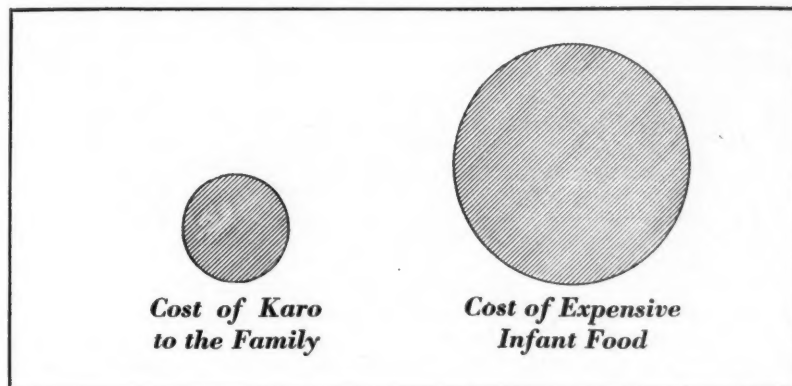
Vacuum-clean or carpet-sweep the carpet. Occasionally have a man or maid take a half pail of water with a few drops of ammonia and start at the point farthest from the door and with a clean scrub brush dipped in and shaken out of the solution, go over the carpet with a circular motion lightly, working toward the door. Leave the carpet untouched for an hour or two, then brush lightly with a corn broom to gather up the little wads of fibers and dust rolled up by the scrub brush. This will brighten up the carpet, but the maid must understand that she is not to lean heavily either on the brush or broom.

The best disinfectant or deodorizer is soap and water cleanliness. Send the mops and cleaning cloths to the laundry daily if at all possible. The smell of a musty mop is most offensive. I have always requested housemen's and maids' closets to be left open a certain period each day, presumably for inspection, but in reality for ventilation.

An exterminating firm will take care of the insect and mouse problem much more cheaply and easily than it can be taken care of by your own crew. Dark corners and rings around pipes hold the water from mops and here is an ideal home for vermin. Men do not like to get down on their knees to clean, but it is necessary to do so in order to scrape away the accumulation in such places. You will find it best to use a small putty knife and steel wool.

Hot sal soda is good for cleaning and deodorizing toilets and drain pipes and will cut your plumbing repair bill considerably with no damage to pipes or porcelain bowls. A disagreeable, but necessary task, especially in the nurses' home, is clearing the bath tub and wash basin drains of hair and lint. You will find the best implement is a crochet hook, with toilet paper to pick up the refuse.

Help the Family Budget by Prescribing KARO FOR INFANT FEEDING



ANY prescribed food which abundantly fulfills the baby's needs—and is available at low cost—is a boon to the mother, a blessing to the father. And the baby thrives! Karo Syrup is an effective carbohydrate. It is well-tolerated, practically non-fermentable, quickly utilized. The low price of Karo is based on its cost — not on its high value as an ideal infant food.



★ Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.

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FOOD SERVICE

Conducted by Anna E. Boller, Rush Medical College

Food Cost Control

By Alberta Macfarlane

THE term "food control" is anathema to many. It is misinterpreted because it envisages a strait-jacketed pattern whereby personal initiative and individual liberty are sacrificed. Such is far from the true picture. Only by efficient control over purchasing, preparation, service, food costs and many other operations can real freedom be secured.

There are no automatic controls in the food game. Efficiency of operation demands steadfast vigilance and exact continuous supervision. No dietary department or restaurant can afford to operate at a loss. For this reason definite controls must be set up. A given percentage must be allotted for food, rent, wages, depreciation, fuel, insurance and other overhead expenses.

How to Arrive at Costs

One of the most effective levers and the one most frequently neglected in the control system is the food cost. Many graduates go out today with little or no knowledge of how to arrive at such a cost. The commercial world, realizing the value of knowing food costs, endeavors to teach its newly acquired dietitian. Too often, with no knowledge of bookkeeping, she flounders in a sea of complexity.

Many institutions check food costs only once a month. This is inadequate, for between these stocktakings, the dietitian is left groping about in the dark, possibly shuffling along in the red. Other institutions have a system of weekly accounting which means that from the cost of the week's operation a daily average cost is obtained. In small institutions, in which the turnover is limited, this may prove effective. For real efficiency, however, a daily food cost is the only solution. A dietitian cannot wander far in the dark with 365 beacon lights each year to guide her.

Many hospitals are using the outmoded monthly method, long discarded by the up-to-date and efficient establishment. Reliable, unpublished statistics show that through intelligent organization and the installation of a daily food cost accounting system

conscientiously carried out, thousands of dollars are saved annually.

Food cost represents an approximate estimate of the cost of raw food materials. In restaurants and hotels food cost is computed on a percentage basis. The efficient manager must know how much of every dollar taken in goes out for food. Hospitals calculate food cost for patients and employees on a per capita basis. This proves for them a convenient method because money is taken in at irregular intervals; meals are often a part of the employee's remuneration, and the rate paid by the patient includes room, board and other items. Thus by means of a per capita cost the amount spent for food per meal or per day, whether patient or employee, is obtained.

No matter how the cost is figured, food remains the largest and most fluctuating article in the budget. Other items such as fuel, labor costs and insurance are more or less stationary.

| Quantity | Item and Description | Smith | | Jones | | Brown | |
|----------|----------------------|--------|-------|--------|-------|--------|-------|
| | | Price | Order | Price | Order | Price | Order |
| 2 crates | Iceberg, 48 heads | \$3.25 | | \$3.50 | | \$3.20 | |

A high food cost not carefully checked and watched may be absorbing percentages that should be used for rent, wages and other items; a low food cost may be accusing as to quality and size of portions.

Keeping of a daily food cost report is a game that can be played with as much interest as any game of contract bridge, if certain standards and methods are set up. The best results do not come by chance or haphazard methods. Each move is deliberately one of thought and concentration, for unprofitable purchases, carelessly planned menus, improperly prepared food or unattractive servings may shoot the food cost far out of line. Therefore eternal vigilance over the minutest detail is the first requisite.

One does not have to be a mathematician, a bookkeeper or a chartered

accountant to install a daily food cost system. However, a little knowledge of bookkeeping is a helpful attribute and the alert person will acquaint herself with the first principles of this subject in order that she may intelligently interpret bookkeepers' accounts.

Records must be devised to fit the individual institution. The information sought is "What has been today's outlay?" All transactions must be carried on in a business-like manner and for this purpose definite records are essential.

Let us consider the records and procedure necessary for a dietary department in an average 300-bed hospital in which the main bookkeeping is done by the central office and only records vital and necessary to the dietary department are kept by the dietitian.

At the beginning of the fiscal year a budget, based on previous experience, should be worked out for this department. The per capita basis allotted will allow a slightly lower rate for the winter months when the volume of business is well maintained and a higher one for the summer when such business reaches a much lower level. With this budget figure in mind, the dietitian now concentrates on the records and methods that will supply her with needed information and assist her in charting her course.

The first requirement will be a purchase order book in which to write the daily market orders and fill in the market quotations when received. Any hard-covered composition book, costing from 25 to 50 cents, will suffice. A form such as the following should be used throughout the book.

When quotations are received and when quality is assured, the order is then placed with the lowest bidder. It may seem necessary to write the confirmation of these orders in triplicate form on a purchase requisition blank. The first copy is white and goes to the vendor; the second copy is yellow and is kept on file in the dietitian's office; the third copy is blue and is delivered to the storeroom man for checking.

This seems an unnecessary procedure if the order book is carefully kept by the dietitian and if the goods upon arrival are checked by her personally as well as by the receiving clerk. Orders are frequently telephoned to the vendor; the goods are delivered and very often in use before this confirmation slip reaches the firm. If such a form is to be used the one at the top of page 94 has proved satisfactory.

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972 Mission Street

| THE MEMORIAL HOSPITAL Dietary Department Purchase Requisition | | |
|---|-------------------------|------------------------|
| Vendor: J. Brown, Inc. | Date: Jan. 11, 1937 | Approved by: Dietitian |
| Quantity | Article and Description | Purchase Price |
| 2 Crates | Iceberg, 48 heads | \$3.20 |

| THE MEMORIAL HOSPITAL Dietary Department Return Slip | |
|---|----------------------|
| Vendor: John Smith & Co. | Date: Jan. 11, 1937. |
| Goods: Loins of pork | |
| Amount: 72 lbs. | |
| Reason for return: Received 9 only, 8-lb. loins. Ordered 9 only, 10 to 12-lb. loins. | |
| Signed _____ Dietitian or Receiving Clerk | |

| DAILY PER CAPITA FOOD COST | | | |
|----------------------------|---------|---------------|----------|
| CENSUS | Today | To date | Total |
| Date: January 1, 1937 | | | |
| Private patients | 128 | | 128 |
| Ward patients | 100 | | 100 |
| Personnel | 200 | | 200 |
| Total | | | 428 |
| EXPENDITURES | | | |
| Private patients | \$68.75 | | \$68.75 |
| Ward patients | 30.00 | | 30.00 |
| Personnel | 80.00 | | 80.00 |
| Total | | | \$178.75 |
| Per capita cost today | 178.75 | = 41.8 cents. | |
| | 428 | | |
| Per capita cost to date | | = 41.8 cents. | |
| Signed _____ Dietitian | | | |

| DAILY PER CAPITA COST REPORT | | | |
|------------------------------|----------|---------------|----------|
| CENSUS | Today | To Date | Total |
| Date: January 2, 1937 | | | |
| Private patients | 105 | 128 | 233 |
| Ward patients | 102 | 100 | 202 |
| Personnel | 200 | 200 | 400 |
| Total | 407 | 428 | 835 |
| EXPENDITURES | | | |
| Private patients | \$ 66.80 | \$ 68.75 | \$135.55 |
| Ward patients | 32.50 | 30.00 | 62.50 |
| Personnel | 81.25 | 80.00 | 161.25 |
| Total | | | |
| | 180.55 | \$180.55 | \$178.75 |
| Per capita cost today | 180.55 | = 44.3 cents. | |
| | 407 | | |
| Per capita cost to date | 359.30 | = 43 cents. | |
| | 835 | | |
| Signed _____ Dietitian | | | |

When delivered the order should be checked as to quality and quantity by both the dietitian and the receiving clerk. If the dietitian placed the order she knows better than anyone else what she expected to be delivered. For this reason she should always supervise the receipt of such goods. Not one item should enter the storeroom that is not duly weighed, counted and checked with the purchase order book and the memorandum invoice. Accurate scales and a few minutes of the dietitian's time employed in this manner may save the institution many dollars by assisting in obtaining value for every dollar spent.

Unsatisfactory goods that have to be returned should be accompanied by a return slip similar to the one at the immediate left.

A note is made of goods returned on the memorandum invoice and on the bill, if the latter accompanies the invoice. On the bill no deduction is made from the total as the firm later sends a credit slip. The driver's delivery slip or invoice is signed by the receiving clerk or the dietitian.

The storeroom man now enters the invoice in a receiving book, similar to the one used by the dietitian as a purchase order book. The dietitian on receipt of the bill checks it as to quantity, price and extensions, and enters it under the correct date in her invoice book. Her record may differ from the storeroom man's by having prices and extensions complete. The invoice is then stamped with an indelible stamp, which bears the name of the institution, the date and the personal signature of the dietitian. At the end of the day all invoices properly stamped are sent to the central bookkeeping department.

A card index file is used to record the purchase of all staple goods. A separate card is used for each item. Entries are made on these cards immediately after the invoices are stamped by the dietitian. References may be made to this file for the name of the vendor, the quantity purchased, the price paid, the brand designated and for the future ordering of goods.

No goods should leave the storeroom without a requisition signed by the dietitian. Except in the case of an emergency, such a requisition should be made out in duplicate form from the menus and recipes on the day previous to the day of delivery. One copy is sent to the storeroom and the other is kept by the dietitian to check the order as it is delivered.

Some purchases, such as bread, milk and ice cream, may be delivered directly to the kitchen. These are checked by a dietitian and the signed invoice kept on file until the daily food cost is computed. Like all other invoices they are written in the invoice book.

In computing the daily food cost the total expenditures for all food requi-

FOR THE DIABETIC DIET . . . Jellied Chicken-Tomato Soup. Add $\frac{1}{4}$ c. hot chicken stock to 3 tbsps. gelatin soaked in $\frac{1}{2}$ c. cold water. When dissolved, add $1\frac{1}{2}$ c. additional stock, 2 c. Libby's Tomato Juice and 1 c. diced chicken. Season to taste and chill. Cut in cubes and serve in bouillon cups.

● Because it is made by an exclusive, patented method (U. S. 1,956,615), no other tomato juice can have just the same fine, rich flavor as Libby's. The Libby method, *gentle press*, takes the pure sweet juice from selected red-ripe tomatoes. ● Different brands of tomato juice not only vary in flavor, they differ too in their content of Vitamin C. Libby's Tomato Juice is accepted by the Council on Foods of the American Medical Association as a *dependably* excellent source of Vitamin C. It also contains Vitamins A, B and G, and valuable food minerals.

Libby's 100 Fine Foods include Fruits and Fruit Juices, Vegetables, Pickles, Condiments, Canned Meats, Evaporated Milk, Alaska Salmon. Each comes in regular and special sizes for institutions. Libby also packs Homogenized Foods for Babies.

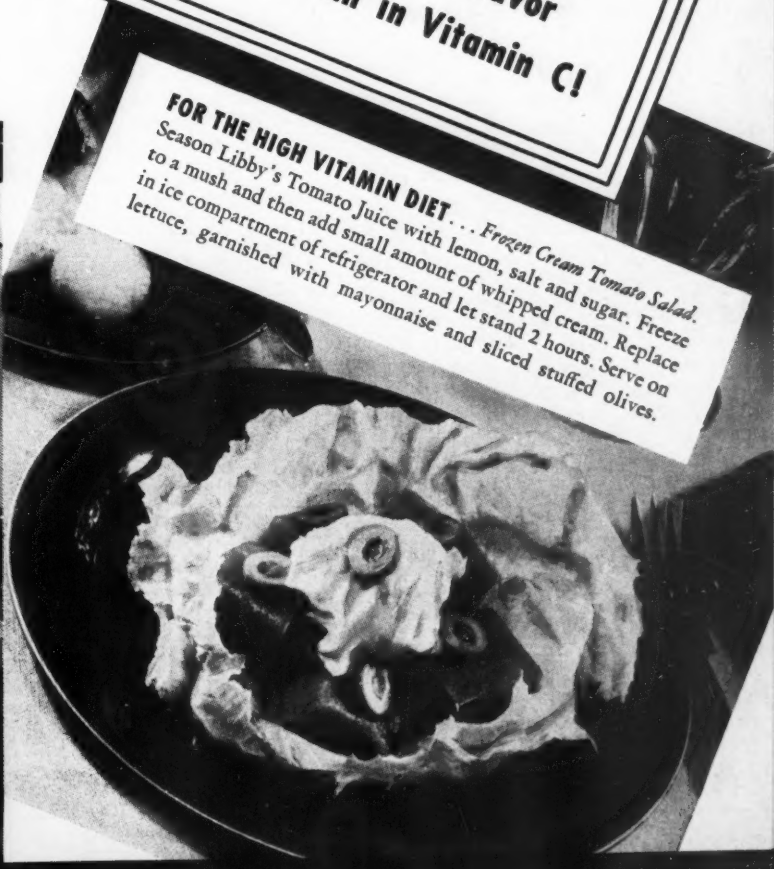
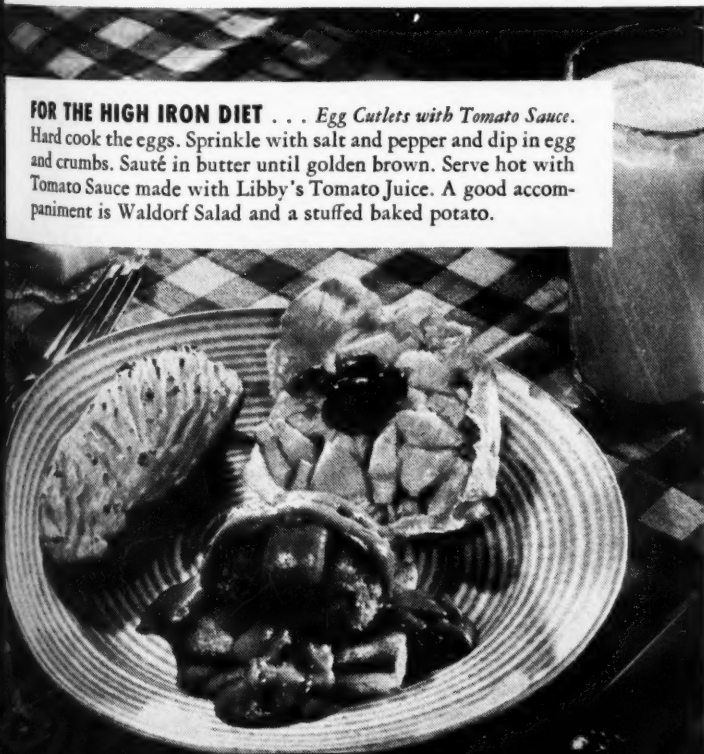
FOR THE HIGH IRON DIET . . . Egg Cutlets with Tomato Sauce. Hard cook the eggs. Sprinkle with salt and pepper and dip in egg and crumbs. Sauté in butter until golden brown. Serve hot with Tomato Sauce made with Libby's Tomato Juice. A good accompaniment is Waldorf Salad and a stuffed baked potato.

FOR THE HIGH VITAMIN DIET . . . Frozen Cream Tomato Salad. Season Libby's Tomato Juice with lemon, salt and sugar. Freeze to a mush and then add small amount of whipped cream. Replace in ice compartment of refrigerator and let stand 2 hours. Serve on lettuce, garnished with mayonnaise and sliced stuffed olives.

Libby's

TOMATO JUICE

Patients prefer its gentle press flavor
And Libby's is dependably rich in Vitamin C!



sitioned from the storeroom and all food delivered directly to the kitchen must be taken into account. The storeroom requisitions are priced, extended, totaled and checked by the dietitian as well as the bills for goods delivered directly to the kitchen, if this has not already been done. If the hospital desires, separate requisitions may be kept for the private patients, ward patients and employees or personnel. A form such as the third form shown on page 94 may be used.

On the following days the aggregate total will be shown as in the form at the bottom of page 94.

Should the supplies for the different departments not have to be kept separately, the form immediately below is suggested.

On the last day of the month and as a check on the monthly performance an inventory is taken after all the goods for the day have been issued.

The dietitian is now ready to draw up a monthly statement. She uses the adding machine to total the monthly purchases as written in her invoice book. The statement is as shown in the form at the bottom of this page.

Such a statement proves the accuracy of her daily food cost reports and gives her the assurance that she has her organization well under control. Her enthusiasm is shown by having her monthly statement finished and on file long before the central office has had time to make a comparative statement for its files.

Space Scheming in Miniature

By Margaret Poindexter

FLOOR space and arrangement of equipment depend entirely upon the character of the service. In a kitchen which caters solely to private patients, the arrangement of equipment necessarily differs from that in a general kitchen serving public ward patients, doctors, nurses and help.

Whether the problem consists of rearranging an existing set-up or organizing a new one really makes little difference, except in determining the size of the room. Once the architect has decided that point, presumably after consulting the building committee, the problem becomes one of more detailed consultation with the dietitian.

Assuming that the number of patients and personnel to be served is known, consultations with practical engineers representing kitchen supply houses are in order. It is better to have as many firms as possible submit ideas, because all will have good ideas as well as impractical ones. Compare their ideas carefully with those you, the dietitian and the building committee have tentatively worked out. I know of no better way of accomplishing this than by having the architect furnish a large scale blueprint of the kitchen floor plan, on a one-half-inch

scale to the foot. Each plan submitted to you previously will have on it the exact size of the stationary equipment recommended, particularly ice box, range, tables, sinks, cabinets, and everything taking up floor or wall space.

With the help of the architect or engineer, the next step is to cut out cardboard miniatures of the equipment on the same scale as the blueprint, using width and length dimensions only. Height need not concern us here. This being completed, move the miniatures around on the floor plan in different positions, considering the window and door spaces, proximity to source of supplies, elevator, dumbwaiter, trash disposal, and ventilation. In this way one can usually visualize the kitchen. After several trials, pick one method which seems best to accommodate all fixed equipment. Care must be taken to assure that hot and cold water supply, drain pipes, gas, steam and electric outlets may be placed in certain places. Remember the necessity of forced ventilation.

The next step necessitates the cutting to scale of movable equipment from cardboard and determining whether the food conveyor, the ice cart, the garbage pail or truck can be accommodated through the doors and aisles. Also, blocks may be cut to scale, representing the maximum number of personnel required in the kitchen at any one time. Do they have room to work? Remember a person takes up more space in a room than that actually occupied by his feet.

Having arrived at a workable plan, repeat the process with a different set-up, attempting to visualize the plan on a large scale. Finally, go through the same process with the preparation table and steam table arrangement keeping ever in mind the number of meals, intermediate feedings and short orders in determining size.

After satisfying yourself that a particular plan is to be chosen, the architect can arrange water, steam, gas and electricity.

Have you in doing all the foregoing planned the general construction of the equipment? Is one piece to be wood, another black cast iron, another white enamel, a fourth stainless steel? Are cabinets movable or permanently attached to the wall? Will they extend from floor to ceiling? Can the highest shelves be conveniently reached by a person of average size? Can the floor be kept clean under each piece of equipment? Will steam, smoke or grease in a short time foul the ceiling? Will the plaster fall from excessive steam and can it be kept clean? What

DAILY FOOD COST REPORT

| | | | |
|-------------------------|----------|----------|---------------|
| Date: January 2, 1937 | | | |
| Storeroom supplies | | \$144.75 | |
| Direct purchases | | | |
| Dairy | | 20.15 | |
| Ice cream | | 10.00 | |
| Bread and rolls | | 5.65 | |
| Total food cost | | | \$180.55 |
| Expenditures | Today | To Date | Total |
| Census | \$180.55 | \$178.75 | \$359.30 |
| | 407 | 428 | 835 |
| Per capita cost today | 180.55 | | |
| | 407 | | |
| | | | = 44.3 cents. |
| Per capita cost to date | 359.30 | | |
| | 835 | | |
| | | | = 43 cents. |

MONTHLY STATEMENT

| | | |
|-------------------------------------|-----------|-------------|
| Cost of food | | |
| Opening inventory, Jan. 1, 1937 | \$ 342.00 | |
| Goods purchased | 5,200.75 | |
| Total cost of food | | \$5,542.75 |
| Closing inventory, Jan. 31, 1937 | | 205.00 |
| Net cost of food for January | | \$5,337.75 |
| Number of persons served 12,709 | | |
| Per capita cost of food for January | 5,337.75 | |
| | 12,709 | |
| | | = 42 cents. |

A Helpful Vehicle in Diabetic Diets

KNOX GELATINE (U.S.P.)

Diabetic diets can be lifted out of their monotonous rut with the aid of Knox Gelatine (U.S.P.). Forbidden foods are not missed so readily when a diabetic patient receives a varied diet containing tasty, pleasing, gelatinized salads and desserts.

Knox Gelatine is 85% protein, making it a simple task to compute any gelatinized dishes. As Knox Gelatine contains no sugar or flavoring, when planning a diet do not confuse it with a ready-prepared jelly powder. Specify Knox Gelatine and be certain.



KNOX GELATINE . . .

is scientifically made from selected long, hard, shank beef-bones — surpasses minimum U.S.P. requirements — contains no carbohydrates — fat content less than 0.1% — odorless — tasteless — bacteriologically safe.

Send the coupon below to receive helpful, informative literature and more fine recipes such as given below.

TOMATO JELLY WITH VEGETABLES (Six Servings)

| | Grams | Prot. | Fat | Carb. | Cal. |
|--------------------------------|-----------|-----------|------------|-------|------|
| 1/2 cup hot water | | | | | |
| 1/2 tsp. salt | | | | | |
| 1/2 tsp. whole mixed spices | | | | | |
| 1 env. Knox Sparkling Gelatine | 7 | 6 | | | |
| 3/4 cup cold water | | | | | |
| 3/4 cup tomatoes strained | 150 | 2 | | 6 | |
| 2 tablespoonfuls vinegar | | | | | |
| 1/2 cup chopped cabbage | 50 | 1 | | 3 | |
| 1/2 cup chopped celery | 60 | 1 | | 2 | |
| 3/4 cup canned green peas | 40 | 1 | | 4 | |
| 1/4 cup cooked carrots cubed | 40 | | | 4 | |
| Total | 11 | 19 | 120 | | |
| One serving | 2 | 3 | 20 | | |

Bring hot water, salt and spices to a boil. Pour cold water in bowl and sprinkle gelatine on top of water. Add to hot liquid and stir until dissolved. Strain into tomatoes and stir in vinegar. Chill until almost set, then add vegetables. Mold and chill until firm. Serve on lettuce with or without dressing.



KNOX SPARKLING GELATINE

KNOX GELATINE LABORATORIES

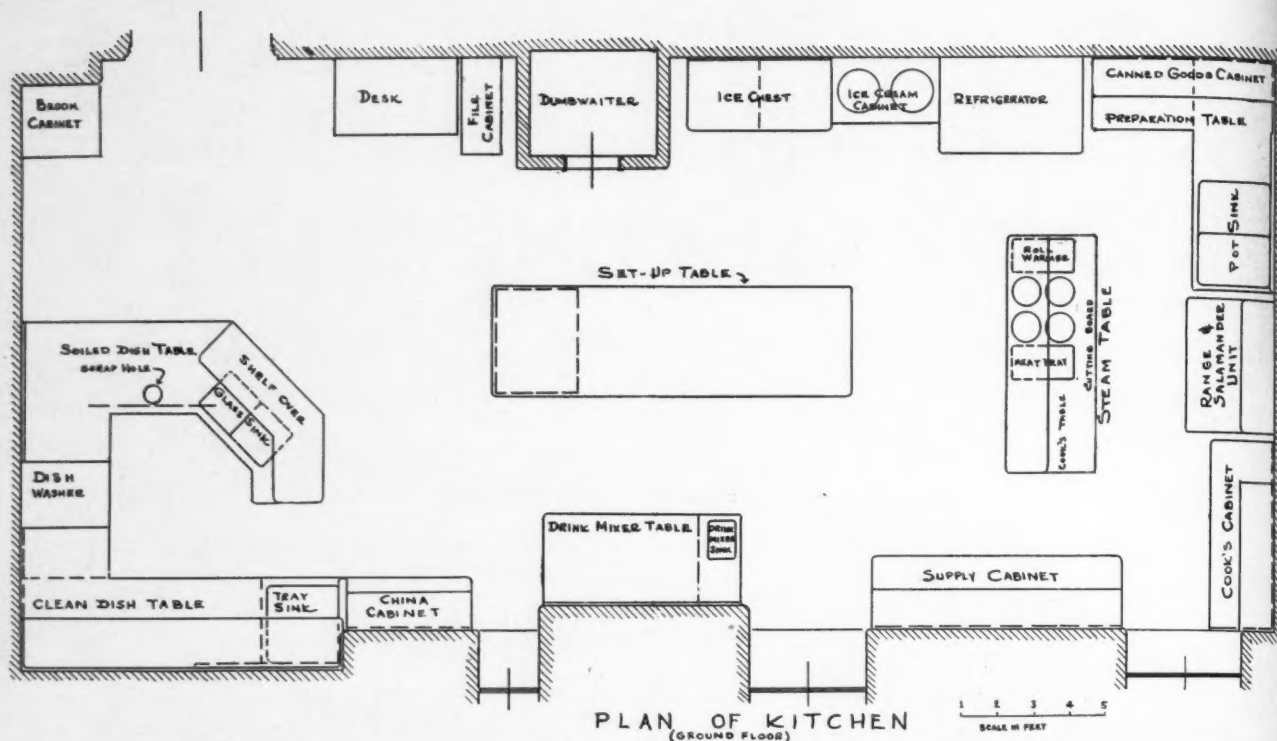
465 Knox Avenue, Johnstown, N. Y.

Please send me diet prescription pads—also infant feeding literature.

Name.....

Address.....

City.....State.....



Layout of furniture and equipment in the kitchen of the new wing at the University of Virginia Hospital.

about the walls, the floors? Will food odors or burning grease odors easily permeate the building?

All these questions must be given consideration to ensure a well planned kitchen.

The Barringer wing, a new unit recently completed and opened at the University of Virginia Hospital, Charlottesville, has a maximum capacity of forty-two private patients. A kitchen in this addition serves all the trays and intermediate feedings. The method

outlined is the one used in arranging and planning the equipment of this kitchen.

All equipment is stainless steel. The floors are of red quarry tile, the walls of glazed brick, and the ceiling of painted cement. The chief reasons for deciding upon these materials were ease of cleaning, durability and the fact that they are practically vermin-proof. Stainless steel, whether of a bright or dull finish, does not readily show the effects of continued usage.

Because of its rust-resisting properties, it does not have corroded areas which harbor dust and dirt and act as a breeding place for vermin such as roaches and water bugs. One of the problems in this section of the country is overcoming these household pests.

All kitchen tables have rounded corners to avoid serious injuries that might result from a person bumping into the sharp corners.

The arrangement was decided upon chiefly for convenience. The serving table is in the center of the room directly in front of the dumb-waiter, and equal distances from the stove and steam table at one end of the room, and the dish washer at the other. A sink for washing pots is beside the stove.

This kitchen has been in operation for one year and the arrangement has been found to be satisfactory.*

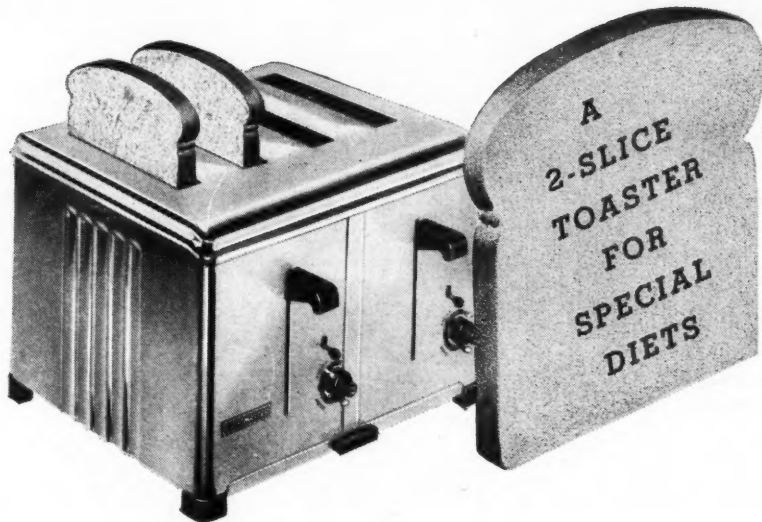
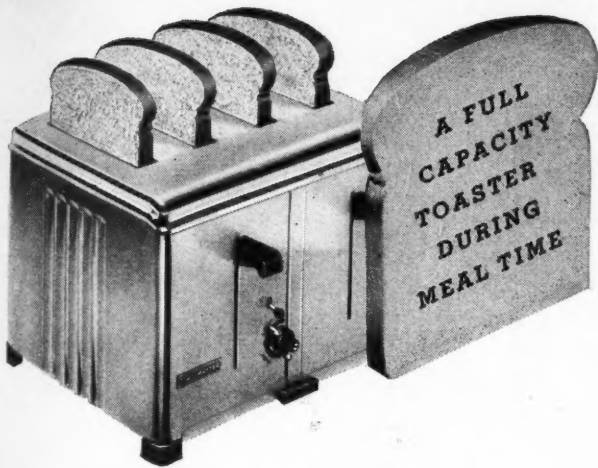


Convenience was the chief consideration in placing the equipment.

Dishwasher Disinfects, Too

Major W. C. Cox, M.C., U. S. A., of Walter Reed General Hospital, Washington, D. C., has been detailed by the commanding officer, General Wallace DeWitt, to study and supervise the operation of dishwashing machines in the diet kitchens of the hospital. Major Cox has made a study of dishwashing machines and is experimenting upon a highly perfected machine which will disinfect eating utensils as well as remove epidemiological evidence. The results will be reported to a committee of the American Public Health Association.

*Read at the meeting of Virginia State Dietetic Association, Roanoke, April, 1937.



You pay no bills for wasted fuel when New TOASTMASTER Toaster makes your toast! It uses current only in slots that are actually working . . . it shuts off the instant the toast is crisp and delicious. Every slice costs less—yet every slice is exactly as your patients like it, because the Flexible Timer can never make a mistake! May we send you complete facts?

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Made in 3, 4 and 6 slice sizes and a heavy duty 2 slice unit for diet kitchens . . . small capacity in a construction that will give years of service.

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MAKES MOST OF THE WORLD'S TOAST

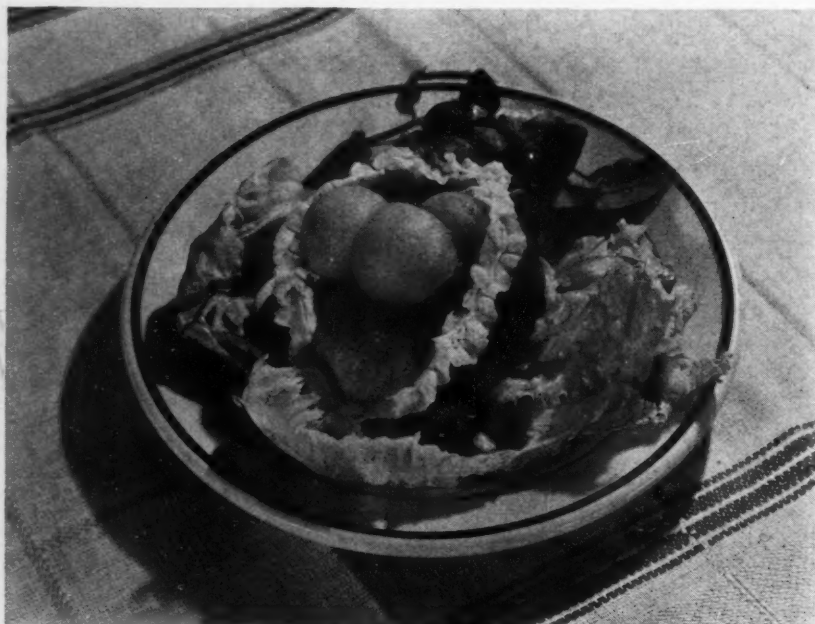
Vol. 49, No. 2, August, 1937

Child's Birthday Tray



Cream of celery soup, poached egg on toast with bacon, baked potato, sliced tomato, ice cream and cup cake, milk.—*Mary Edna Golder, chief dietitian, St. Anne's Hospital, Chicago.*

August Salad



Lettuce
Tomato

Cheese

Melon balls
Cress

On a nest of lettuce, place a thick slice of a large tomato (from which seeds and connective pulp have been removed). Fill the center of the tomato with several balls cut from various kinds of melon. Pipe a border of cream cheese around the edge of the tomato and garnish with a pompon of cress. Serve with French dressing. As in Marinated Melon Salad, if melon balls are made from flat or under-ripe melons, they should be marinated.—*Arnold Shircliffe.*

FOOD FOR THOUGHT

• Right now, with the papers full of strikes and labor difficulties, the labor problems in the hospital are also commanding attention. Already there has been trouble in some institutions, and others are anticipating trouble, unless something drastic is done. In an attempt to prevent difficulties of this type, the administration section of the American Dietetic Association is sponsoring a study of the labor policies in nonprofit institutions. This committee is asking for information on individual positions and on the labor policies for all employees in all departments. The more institutions that cooperate in this study, the greater will be its value. Have you sent in your contribution?

• Bertha Ide, dietitian at Norfolk Protestant Hospital, Norfolk, Va., has worked out the ever-present guest tray problem in an interesting way. Up to a year ago that institution served guest trays to friends and relatives, which were ordered by the head nurse on the floor to which they were to be sent. The charge was made out by the dietitian, sent to the business office and charged on the patient's bill. The rate was 50 cents for breakfast, \$1 for dinner, and 75 cents for supper. Now a cafeteria has been installed in which doctors and visitors are served. A card on the back of the door of each patient's room describes the service. Tickets are sold at the business office at the rate of 50 cents for breakfast, 75 cents for dinner and 50 cents for supper. These are placed in a box in the cafeteria when the person is served. Those persons who do not desire an entire meal are charged only for what they wish. This arrangement has proved satisfactory, as it takes the extra work out of the diet kitchen, where the tray service is heavy at all times.

On the other hand, Grace Carden, dietitian at Strong Memorial Hospital, Rochester, N. Y., reports that she finds it most convenient to serve meals to guests of patients on private floors via the guest tray method. A flat price of \$1 is charged for any meal. These meals are ordered by the nurse in charge, who puts a charge slip through to the cashier's office to be put on the patient's bill.

• At this time of the year, it is well for the dietitian to bear in mind that it is hard to be in the hospital in hot weather, and that possibly many patients have been in bed during the entire summer. This is a splendid time to spring any little surprises in the way of different desserts, crisp salads or cooling beverages that the dietitian may have up her sleeve. Sandwich suppers are always popular and there are many interesting new sandwich fillings to tempt lagging appetites.

"DOCTOR, HE JUST WON'T EAT"

A Special Food Supplement Added to the Child's Diet

Frequently Improves Appetite and Helps to Correct Underweight

OVALTINE is the food supplement which many doctors are recommending to help restore appetite and add weight. It contributes to weight gains in several ways—

First—Ovaltine helps to restore normal appetite. It tempts the taste and in addition, it helps to stimulate the lagging appetite. It contains 57 International units per ounce of the appetite-restoring vitamin B. It also makes possible the prompt return of hunger by causing the stomach to empty starchy foods more rapidly. (See x-rays below).

Second—Ovaltine possesses other special prop-

erties which are also important when digestion is under par. It not only aids the digestion of starchy foods, but it increases the digestibility of milk. Furthermore, Ovaltine itself is very easy to digest.

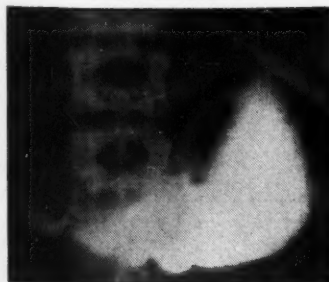
Third—Ovaltine adds important growth factors to the diet. It contains complete proteins, easily available carbohydrates, vitamins A, B₁, B₂ (G), and D, and the minerals calcium, phosphorus and iron.

Developed in Switzerland over 40 years ago as a food for convalescence, Ovaltine has stood the test of time. It makes an ideal food for underweight children because it combines both nourishing and protective food elements in an attractive form. Recommend the use of Ovaltine for underweight children and see for yourself the results it can bring.

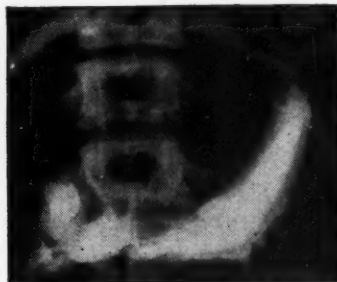
Let us send you a regular size can of Ovaltine for clinical trial with some undernourished child under your care. Address The Wander Company, 360 North Michigan Avenue, Chicago, Ill., Dept. M. H. 8.

Copr. 1937, The Wander Co.

(Without Ovaltine)



(With Ovaltine)



The two x-ray reproductions show the stomach two hours after a starch meal was taken, with and without Ovaltine. The average decrease in gastric contents due to Ovaltine was 20%.

September Breakfast and Supper Menus

By Elizabeth Hayward

Dietitian, Las Encinas Sanitarium, Pasadena, Calif.

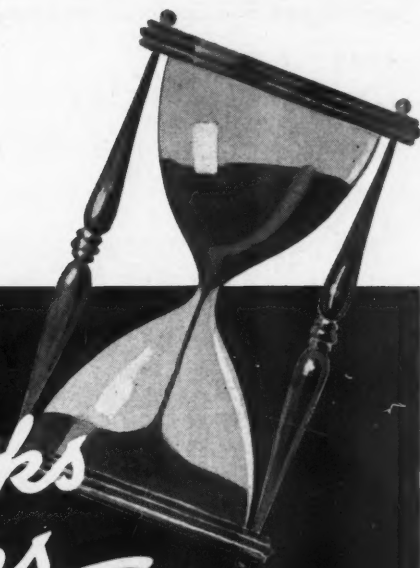
BREAKFAST

SUPPER

| Day | Fruit | Main Dish | Main Dish | Vegetable | Salad or Relish | Dessert |
|-----|-----------------|---|--|--------------------------------|---|-------------------------------------|
| 1. | Melon | Eggs and Bacon or Hot Cakes With Marmalade | Loin Chop and Lima Beans | Broccoli | Apple and Pear Salad | English Toffee Ice Cream |
| 2. | Grapefruit | Eggs and Bacon | Chicken Soufflé With Mushroom Gravy | Brussels Sprouts, String Beans | Fan Fruit Salad | Chocolate Roll |
| 3. | Figs | Eggs and Bacon or Hot Cakes | Assorted Cold Meats With Pear Salad | Harvard Beets | Asparagus Salad | Raspberry Ice, Cookies |
| 4. | Sliced Oranges | Eggs and Bacon, Jam | Broiled Sweetbreads With Rice Fritters | Artichoke Soufflé | Vegetable Salad | Cobbler |
| 5. | Melon | Eggs and Bacon, Coffee Cake and Jam | Manhattan Soup, Assorted Sandwiches | Okra and Tomatoes | Sugar Plum Salad | Raspberry Ice |
| 6. | Prunes | Eggs and Bacon | Avocado With Lobster and American Cheese | Peas | Pickled Beets | Lemon Layer Cake |
| 7. | Apricots | Eggs and Bacon, Jam | Loin Chop With Broccoli | Lima Beans | Lettuce Salad | Pumpkin Custard or Melon |
| 8. | Melon | Eggs and Bacon or Hot Cakes With Grapefruit Marmalade | Rice Croquettes With Blackberry Jelly and Fried Green Tomato | String Beans | Pear and Philadelphia Cream Cheese Salad | Blueberry Pie |
| 9. | Sliced Oranges | Eggs and Bacon or Waffles With Apricot Jam | Liver and Bacon With Mashed Rutabagas | Peas | Sliced Tomatoes | Peach Ice Cream |
| 10. | Berries or Figs | Eggs and Bacon, Muffins | Vegetable Plate, With Scrambled Brains, Zucchini | Corn, Carrots | Frozen Fruit Salad | Cheese Cake |
| 11. | Melon | Eggs and Bacon or Hot Cakes With Jam | Spanish Meat Balls, Tomato Sauce, Wild Rice | Wax Beans | Sugar Plum Salad | Tutti-frutti Ice Cream |
| 12. | Grapefruit | Eggs and Bacon or Coffee Cake With Jam | Baked Grits With Sausage and Syrup | Swiss Chard With Egg | Tomato Salad | Fresh Pears |
| 13. | Prunes | Eggs and Bacon | Baked Beans or Mushrooms With Artichoke | Spinach | Cottage Cheese and Pear Salad | Lemon Pie |
| 14. | Raspberries | Scrambled Eggs and Bacon or Oatmeal Muffins and Jam | Vegetable Plate | | Chicken Salad | Watermelon |
| 15. | Figs | Eggs or Waffles and Sausage | Avocado With Lobster and Finger Pineapple Sandwiches | Peas and Carrots | Tomato Juice | Burnt Almond Ice Cream |
| 16. | Grapefruit | Eggs, Berry Jam | Baked Liver, Vegetable Sauce and Lima Beans | Swiss Chard | Fresh Fruit Salad | Chocolate Roll |
| 17. | Applesauce | Eggs and Bacon or Hot Cakes | Chicken Shortcake | Beets | Apricot Salad | English Toffee Ice Cream |
| 18. | Oranges | Eggs and Bacon, Corn Muffins | Ham Soufflé With Sweet Potato Nut Rolls, Fried Apples | | Vegetable Salad | Melon |
| 19. | Melon | Eggs and Bacon, or Coffee Cake and Jam | Assorted Sandwiches, Escalloped Zucchini | Artichoke Soufflé | Fruit Salad | Banana Cream Cake |
| 20. | Prunes | Eggs and Bacon | Corned Beef Hash With Poached Egg | Peas | Sliced Tomatoes | Apricot Pie |
| 21. | Melon | Eggs and Bacon or Hot Cakes | Finnan Haddie on Toast | String Beans | Tomato Salad | Fresh Peaches |
| 22. | Prunes | Eggs, Ham, Waffles | Meat Balls, Tomato Sauce and Corn on Cob | Crook Neck Squash | Jellied Fruit Salad | Ice Cream |
| 23. | Apricots | Eggs and Bacon or Muffins With Jam | Veal and Noodles With Artichoke | Cauliflower | Deviled Egg Salad | Melon |
| 24. | Oranges | Eggs and Bacon or Hot Cakes | Broiled Sweetbreads and String Beans | Swiss Chard | Banana-Nut Salad | Vanilla Ice Cream With Fruit Sauce |
| 25. | Raspberries | Eggs and Bacon, Gems | Loin Chops With Spinach Loaf | Lima Beans | Apple and Pear Salad | Chocolate Pie |
| 26. | Fresh Figs | Eggs and Bacon or Coffee Cake | Baked Grits With Sausage and Syrup or Oyster Stew | Spinach | Tomato and Avocado Salad | Fresh Pears |
| 27. | Grapefruit | Eggs and Bacon | Cold Ham and Turkey, Cranberry Sauce | Peas | Asparagus Salad, Thousand Island Dressing | Strawberry Shortcake, Whipped Cream |
| 28. | Oranges | Eggs and Bacon or Muffins and Jam | Macaroni and Cheese, Breaded Tomatoes | String Beans | Tuna Fish Salad | Raspberries, Vanilla Cookies |
| 29. | Prunes | Eggs and Bacon or Hot Cakes | Chicken Legs and Gravy With Natural Rice | Spinach | Peach and Cottage Cheese Salad | Watermelon |
| 30. | Applesauce | Eggs and Bacon or Hot Cakes and Jam | Vegetable Plate | Spinach Loaf | Shrimp Salad | Loganberry Tarts |

Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago. Space precludes listing of cereals, breads and beverages. Several varieties of well known cereals are always offered for breakfast.

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to know...



that
Ralston cooks
in 5 minutes

The starch in Ralston is completely gelatinized after five minutes' cooking over an open flame. This ease of preparation makes Ralston doubly desirable since so many nutritionists prefer a hot whole wheat cereal, double-rich in vitamin B. Ralston is

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Wheat Cereal
Enriched with
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• **A WHOLE WHEAT CEREAL...** with only the coarsest bran removed... providing an abundance of the body-building, energy-producing elements that come from choice whole wheat.

• **DOUBLE-RICH IN VITAMIN B...** pure wheat germ is added to Ralston to make it 2½ times richer in vitamin B than natural whole wheat.

• **PALATABLE AND ECONOMICAL..** tastes so good that the whole family likes it—and each generous serving costs less than one cent.

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Laboratory Report on Ralston Wheat Cereal.

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NEWS IN REVIEW

Preliminary Program Announcement Reveals Strong List of Speakers for A.H.A. Convention

From the illustrious list of speakers and the variety of sectional meetings arranged, the incomplete program of the American Hospital Association's convention just released indicates that it may easily be the association's best convention.

The thirty-ninth annual conclave will be held from September 13 to 17 at Atlantic City with six allied groups meeting concurrently: the American Protestant Hospital Association, the American College of Hospital Administrators, the American Association of Nurse Anesthetists, the American Association of Occupational Therapists, Medical Social Workers and the Children's Hospital Association.

Guest Speakers Listed

Heading the list of guest speakers are Capt. J. E. Stone, secretary of the Hospitals Centre of Birmingham, England; Gov. Harold G. Hoffman of New Jersey; WPA Administrator Harry L. Hopkins; William J. Ellis, New Jersey commissioner of institutions; President William A. Sumner of the board of trustees of the Paterson General Hospital, Paterson, N. J.; David B. Skillman, president of the board of trustees of the Easton Hospital, Easton, Pa.; Fred K. Hoehler, executive secretary of the American Public Welfare Association, Chicago; the Rev. John J. Bingham, assistant director, division of health, Catholic Charities, New York City; David McAlpin Pyle, president of the United Hospital Fund of New York City; Dr. Joseph W. Mountin, U. S. Public Health Service; Allen T. Burns of the Community Chests and Councils, New York City; Dr. S. S. Goldwater, New York City commissioner of hospitals; Dr. Joseph C. Doane, editor of *The Modern Hospital*; Bertha W. Mears; Mary K. Bazemore; Ruth Hartley Weaver; Philip S. Barba; Charles P. Major; John C. Williams; H. A. Pattison; Walter C. Reineking, Lake View Sanatorium, Madison, Wis.; John Nicklas, Grasslands Hospital, Valhalla, N. Y.; B. P. Potter, Hudson County Tuberculosis Hospital and Sanatorium, Secaucus, N. J.; Dr. Foster Murry, Brooklyn, N. Y.; R. E. Plunkett, State Health Department, Albany, N. Y.; Bernard S. Coleman, New York Tuberculosis Association, New York City; Dr. M. Pollak, Peoria Municipal Tuberculosis Sanitarium, Peoria, Ill., and Ernest E. Bishop.

The section meetings will include

discussions on administration, children's hospitals, construction, dietetics, group hospitalization, mechanical divisions, nursing, out-patient, public hospital, purchasing agents, small hospitals, social service, hospital trustees and tuberculosis.

Among the speakers will be authorities in each field. Five leading architects who will speak are Carl A. Erikson and Perry W. Swern, Chicago; H. Eldridge Hannaford, Cincinnati; Edward F. Stevens, Boston, and B. Evan Perry, Toronto.

The hospital administrators whose names appear in the incomplete program include Ada Belle McCleery, Evanston Hospital, Evanston, Ill.; E. Muriel Anscombe, Jewish Hospital, St. Louis; Nellie G. Brown, Ball Memorial Hospital, Muncie, Ind.; Mabel Henry, Graham Hospital, Keokuk, Iowa; Dr. Allan Craig, Charlotte Hungerford Hospital, Torrington, Conn.; Melvin L. Sutley, Delaware County Hospital, Drexel Hill, Pa.; Clyde Sibley, Birmingham Baptist Hospital, Birmingham, Ala.; Robert E. Neff, University of Iowa Hospitals, Iowa City; James U. Norris, Woman's Hospital, New York City; Dr. E. M. Bluestone, Montefiore Hospital, New York City; Dr. Basil C. MacLean, Strong Memorial Hospital, Rochester, N. Y.; Dr. Donald C. Smelzer, Graduate Hospital of the University of Pennsylvania, Philadelphia; Joseph J. Weber, Vassar Brothers Hospital, Poughkeepsie, N. Y.; Fred W. Heffinger, Mercer Hospital, Trenton, N. J.; Mary A. Rothrock, Clearfield Hospital, Clearfield, Pa.; Netta Ford; Blanche Pfefferkorn, National League of Nursing Education; Anna D. Wolf, New York Hospital, and Ethel G. Prince, president, New York State Nurses Association.

Dietitians on Program

Among the dietitians will be Ella Eck, University of Chicago Clinics; Kathleen Lewis, Johns Hopkins Hospital, Baltimore; Nelda Ross, Presbyterian Hospital, New York City; Lute Trout, Indiana University Hospitals, Indianapolis, and Ruth Weldman, Travis House, Williamsburg, Va.

The social workers include Hester W. Browne, Grasslands Hospital, Valhalla, N. Y.; Edith C. Seltzer, Welfare Council, New York City; Eleanor Cockerill, Barnard Free Skin and Cancer Hospital, St. Louis, and Ursula A. Cronin, tuberculosis division, social service section, Grasslands Hospital.

Round table discussion leaders will be Dr. Malcolm T. MacEachern, associate director, American College of Surgeons; Robert Jolly, Memorial Hospital, Houston, Tex.; Dr. Robin C. Buerki, State of Wisconsin General Hospital, Madison, and Asa S. Bacon, Presbyterian Hospital, Chicago.

Special features of the convention, in addition to the round tables, will be clinical demonstrations, sound motion pictures of hospital operation, technical exhibits, educational exhibits, a golf tournament and hobby display.

A. C. H. A. Will Map Future at Atlantic City Meeting

Presentation of the final report of the committee on training hospital administrators under Dr. Malcolm T. MacEachern, chairman, and the announcement of future plans and policies to be pursued will comprise the main events on the program of the fourth convocation of the American College of Hospital Administrators in Atlantic City, September 12 to 17.

This year will mark the introduction of the new junior membership in the A. C. H. A. Capt. J. E. Stone, secretary of the Birmingham Hospitals Centre, Birmingham, England, an honorary fellow of the A. C. H. A., will give the address on the evening of induction of newly elected fellows and members. Captain Stone also is appearing upon the A. H. A. convention program.

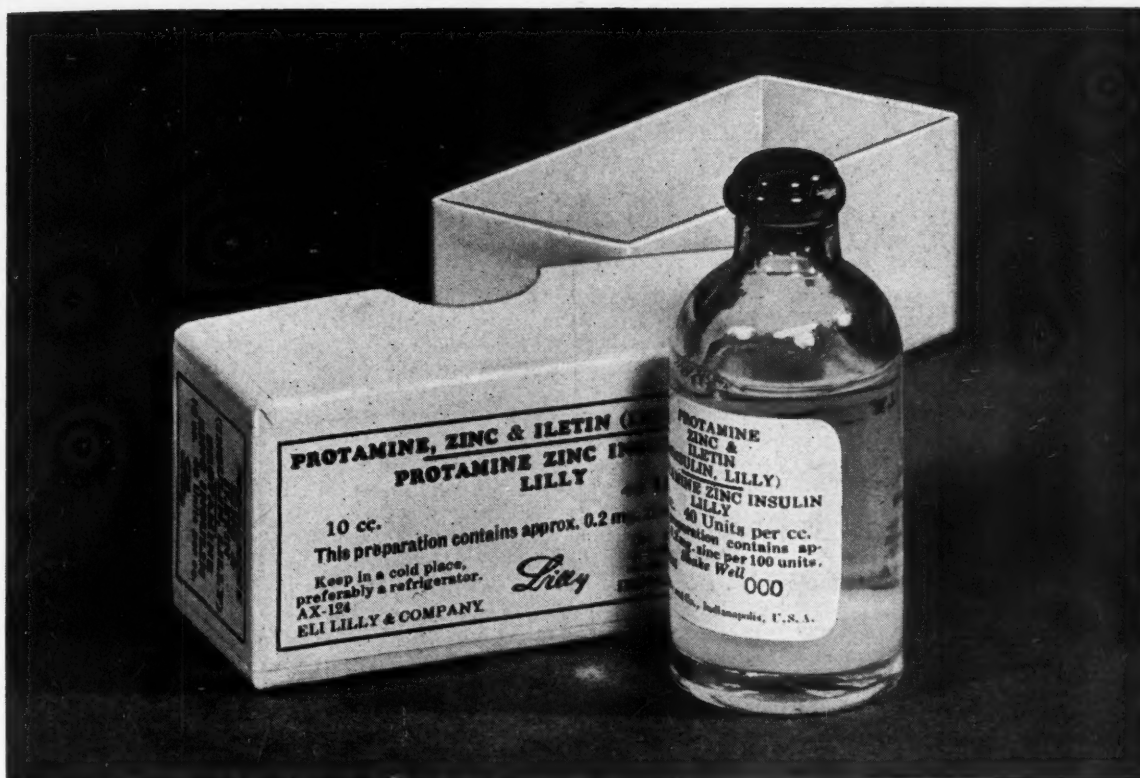
At the business session of the convocation, the revised constitution and by-laws again will be submitted for vote by the membership. Recent strides made by the college and the status of its budget also will be reported upon.

Students Travel Far to Hospital Institute

Already applications from students in Venezuela, Santo Domingo, Puerto Rico and Korea have been received for the fifth annual institute for Hospital Administrators to be held in Chicago, August 30 to September 10. Approximately 100 registrations are expected.

The institute will be sponsored by the American Hospital Association, with the University of Chicago, the American College of Hospital Administrators, the Chicago Hospital Association, the American College of Surgeons and the American Medical Association cooperating.

Clinical demonstrations will be staged at sixteen hospitals in the metropolitan area of Chicago, during the afternoon sessions. The mornings will be devoted to seminars and panel discussions, conducted in Judson Court on the campus of the University of Chicago. Four evenings of each week will be given over to round table discussions led by Dr. Malcolm T. MacEachern and his associates in the American College of Surgeons.



PROTAMINE, ZINC & ILETIN (INSULIN, LILLY)

PROTAMINE ZINC INSULIN LILLY

PROTAMINE, Zinc & Iletin (Insulin, Lilly) was developed as a result of co-operation with Dr. H. C. Hagedorn and his associates of Copenhagen, Denmark, and the University of Toronto.

Protamine Zinc Insulin represents a step forward in the management of diabetes and in many

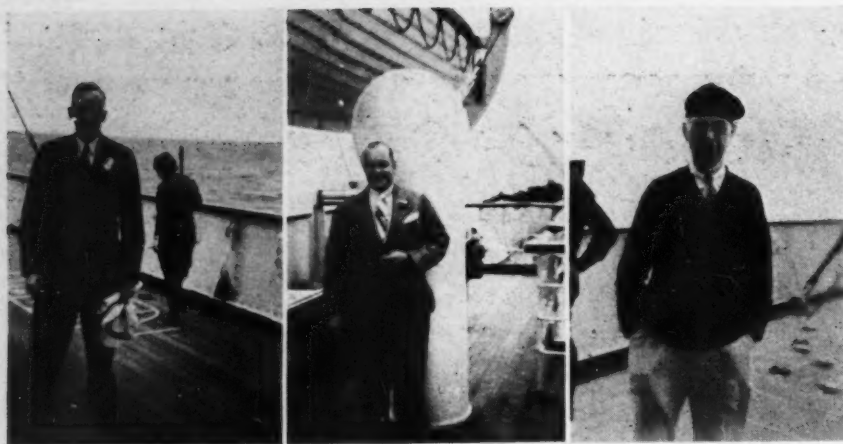
cases offers definite advantages over unmodified Insulin in treating the diabetic.

In order that the physician may have his choice, pharmacists should maintain adequate stocks of both Protamine, Zinc & Iletin (Insulin, Lilly) in 10-cc. vials, 40 units per cc., and Iletin (Insulin, Lilly) in its various strengths.

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Stanley Howe, Doctor Munger and Architect Stevens aboard the Britannic.

Paris Is Solicitous Host to International Hospital Congress; Toronto Is Next Stop

The fifth International Hospital Congress was held in Paris from July 5 to 11. All of the sessions took place at the Congress Headquarters. Dr. G. von Deschwanden of Zurich presided. The meetings were divided into (a) plenary sessions, of which there were six, (b) study committees and subcommittees, (c) visits to specialized technical establishments, (d) visits to establishments controlled by the Paris Poor-Law Board and (e) receptions of various kinds.

Meeting Well Attended

A total of 678 delegates representing thirty-six nations attended.

The opening (plenary) session was held on July 5 at 3 p.m. This was followed by a formal reception at the City Hall by the officials of the city of Paris. On July 6 there was a plenary session followed by meetings of the various study committees, such as: (1) construction, Architect Distel of Hamburg; (2) administration, Doctor Barthelme of Strasbourg; (3) accounting and finance, Doctor Oster of Strasbourg; (4) legislation, Doctor Mouttet of Bern; (5) spiritual care and social service, Doctor Kreutz of Freiburg and Mrs. Getting of Paris; (6) libraries, Marjorie Roberts of London; (7) general medical care, Doctor Hekman of Rotterdam, and (8) surgery, radiology, venerology and dietetics under various chairmen.

There were also subcommittees on personnel, statistics and nomenclature, outside relationships and air defense. On this day, as on the other days of the congress, there was a private reception for the delegates by various people prominent in Paris society, such as Mme. Gillet, Mme. Sommer, Mme. Balsan and Doctor Mourier, director general of the Assistance Publique of Paris.

The next five days were similarly

opened with a plenary session followed by study committee meetings and receptions. During the course of the week there were technical visits by the delegates to a number of new buildings, such as the Institut du Cancer, the Fondation Foch, and the Beaujon Hospital.

On the evening of July 8 members of the American, English and Irish delegations gave a formal dinner to the French organizing committee and to the executive officers of the congress at the Restaurant Langer on the Champs Elysees.

The following delegates represented the American Hospital Association at the congress: Dr. Claude W. Munger, president of the American Hospital Association; Dr. G. Harvey Agnew, secretary of the Department of Hospital Service, Canadian Medical Association, and Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons. Father Georges Verreault, Ottawa, represented the Catholic hospitals of America and Canada.

Strong American Delegation

Other Americans present at the meeting included Dr. E. M. Bluestone of New York City; Stanley Howe of Orange, N. J.; Mr. and Mrs. Edward F. Stevens of Boston; Dr. and Mrs. E. E. Shifferstine of Philadelphia; M. Burneice Larson of Chicago; Mr. and Mrs. Howard E. Bishop of Sayre, Pa.; Dr. George O'Hanlon of Jersey City, N. J.; Edna Price of Concord, Mass.; Jennie M. Huff of Pennsylvania, and Dr. A. J. Hockett of New Orleans.

The French proved to be generous and solicitous hosts and the delegates were able to spend their leisure time at the exposition located within a block of the congress halls.

The next meeting will be in Toronto, Canada, in 1939.

BEQUESTS AND GIFTS

NEW HAVEN, CONN.—Yale University has received a fund, said to be in the neighborhood of \$10,000,000 from anonymous donors to be used for investigation into the causes and origin of cancer. The gift will be known as the Jane Coffin Childs Memorial fund in honor of the late Mrs. Jane Childs, a daughter of an early president of the General Electric Company.

MACON, GA.—R. J. Taylor, Macon capitalist, has donated an additional \$15,000 to the building of a hospital in Hawkinsville. Several weeks ago Mr. Taylor gave \$50,000 toward the erection of the hospital, which will be a memorial to his father and grandfather, both of whom were Hawkinsville physicians.

JACKSON, MISS.—The late Richard Greene, one of Mississippi's foremost philanthropists, left his residuary estate of \$350,000 or \$400,000 for establishing a free hospital for Negroes here, or for the purpose of building wards for Negro patients in some hospital already established.

MINNEAPOLIS.—The Rockefeller Foundation has given \$36,000 to the University of Minnesota for research in biology and medicine. The project will involve the construction of high voltage equipment in the physics laboratory, consisting principally of a giant Van de Graff generator capable of producing from six to eight million volts of electricity.

NEW YORK CITY.—One-half the estate of the late Mrs. Mathilda Watson, valued at more than \$100,000, has been willed the New York Post Graduate Medical School and Hospital.

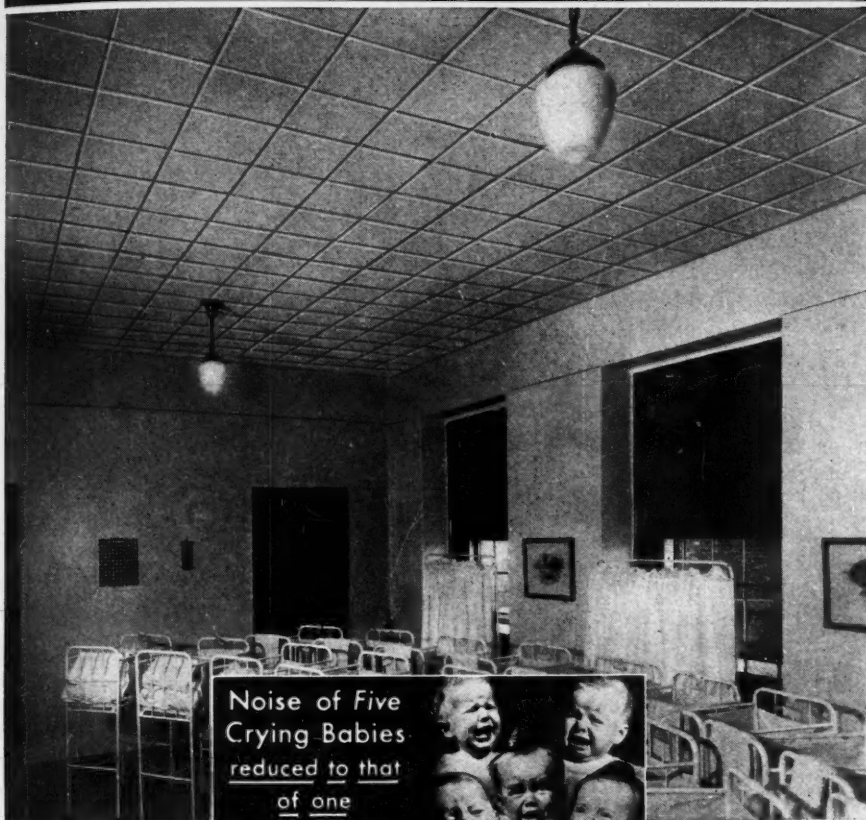
WHITE PLAINS, N. Y.—A gift of \$75,000 to the building fund for the new White Plains Hospital has been made by an anonymous donor, who specified that the gift be used for a memorial to Dr. H. Ernst Schmid, who for half a century was widely known in the community as a physician.

PORT CLINTON, OHIO.—Howard B. Magruder, late retired banker, left a trust fund estimated at \$200,000 for establishing a hospital to be known as the H. B. Magruder Memorial Hospital of Port Clinton.

PHILADELPHIA.—Bequests of \$5,000 have been made to Lankenau Hospital by Mrs. Emma V. Arthur, and to Episcopal Hospital by Elizabeth Helfenstein. . . . The Methodist Episcopal Hospital has been left \$25,000 by the will of Sarah E. Simpson. . . . By the will of Mrs. Letitia White, widow of Dr. J. William White, Maternity Hospital and University Hospital have been bequeathed \$15,000 and \$5,000, respectively, to provide a prize each year for the nurse graduating at the head of her class. . . . The sum of \$200,000 from the estate of Frances T. Kinsey will be used for the study and treatment of diseases of the digestive system at University Hospital.

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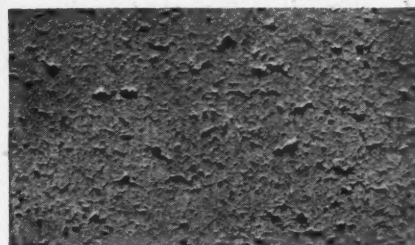
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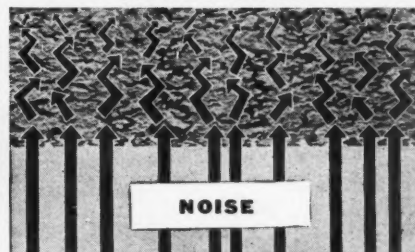
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States Rapidly Adopt Group Hospitalization as Legal, Traditional Barriers Are Cleared Away

With the bans of legality and prejudice gradually falling away, various states are adopting group hospitalization plans as rapidly as the barriers are cleared from their progress. Five new groups have reported organization, and five others who have had plans in operation for some time report progress and increase in enrollments.

The Association of California Hospitals was instrumental in the passage of a new bill in the recent session of the state legislature, which has just been signed by the governor, making possible group hospitalization as a special service act without qualifying as insurance companies. This bill was worked out with assistance of the California Medical Association's attorney, the attorney for the insurance commissioner and attorneys for the hospital association. As a new venture in group hospitalization legislation, it places hospitals and associations under proper supervision, thus eliminating racketeers.

Some twenty-seven hospitals in Southern California are organizing under the act and will be ready to function when the law becomes effective on August 27. The state insurance commissioner and other state departments are cooperating in offering this service to the public.

With the signing by Pennsylvania's governor, George H. Earle, of bills permitting incorporation for nonprofit hospital service plans, group hospitalization for the Pittsburgh district will be available just as soon as administrative work necessary for launching of the plan can be completed, Abraham Oseroff, secretary of the Hospital Council of Allegheny County, announced. The Hospital Council now is extending its membership to hospitals throughout Western Pennsylvania, in addition to its activity of launching the "three-cents-a-day" plan for hospital service.

Low Cost Group Plan

Under the Allegheny hospitalization plan a subscriber would be eligible for twenty-one days of semiprivate hospital service for approximately 72 cents per month. Subscribers would be enrolled on the basis of ten or more employed persons to ensure a fair cross section; a provision is included for extending such protection to members of the subscriber's family when desired.

Officers of the Hospital Council of Allegheny County are Ralph W. Harbison, president of the board of trustees of the Presbyterian Hospital, president; H. Lee Mason, Jr., chairman of the executive committee of the Allegheny General Hospital, vice president; A. E. Braun, prominent Pittsburgh banker, treasurer, and Mr.

Oseroff, director of the Montefiore Hospital, secretary.

A plan similar to the Pittsburgh plan and under the same state regulations is said to be going into effect in Philadelphia at this time.

In Chicago the Plan for Hospital Care has enrolled since January 1 approximately 18,000 persons from 240 industrial and commercial organizations. Because of the extension of its activities, the Plan for Hospital Care has moved into new offices in the Merchandise Mart. Since January 1, 340 cases were reported cared for in hospitals. About 80 per cent of the subscribers to the Chicago plan are on pay roll deduction, it was said.

Frank Van Dyk, executive director of the Associated Hospital Service of New York, has announced that enrollment in the two-year-old nonprofit hospital plan has passed the 400,000 mark. New York's hospital plan, he said, is the largest organization of its kind in America. The total paid to 240 member hospitals since the plan went into effect is slightly more than \$1,500,000 at the present time.

Pay by Western Union

Under a new arrangement with the Western Union Telegraph Company, subscribers to New York's three-cents-a-day plan may make their subscription payments at Western Union offices in the New York area. The telegraph company will charge the subscriber a seven-cent fee, a uniform rate, for transmitting the payment to the Associated Hospital Service headquarters.

During the month of June the Hospital Saving Association of North Carolina reported that it had brought its total enrollment within striking distance of the 30,000 mark with 2,046 new members in seventy-eight new groups.

Cleveland, which has had its Hospital Service Association since 1934, has now enrolled nearly 50,000 employed citizens of Cuyahoga County. The association has a reserve and surplus of \$102,444.14, and has paid hospitals for care rendered to employed and family subscribers, \$291,200.32.

The Cleveland plan has been set up on a nonprofit basis that precludes exploitation. After a reasonable reserve has been accumulated, either lower rates must be offered or else benefits added to the contract, such as a longer period of hospitalization than twenty-one days.

A vigorous debate on group hospitalization featured the meeting of the Mississippi State Hospital Association which was held in Meridian on May 10. The division of opinion was over the question of developing group hospitalization under the auspices of the state hospital association.

A. E. Hardgrove, assistant executive secretary of the American Hospital Association, outlined the principles of group hospitalization approved by the association. It was finally decided that the association should develop a state-wide, nonprofit plan and not give encouragement to proprietary plans.

A bill providing for group hospitalization has been passed by the Georgia legislature and signed by the governor, and the formation of a group hospitalization corporation in Atlanta, Ga., is under way. Dr. L. C. Fischer of the Crawford W. Long Hospital, Atlanta, took leadership in getting the bill through the legislature.

A new group hospitalization plan has been inaugurated in Boston with the selection of Reginald F. Cahalane as executive officer. Mr. Cahalane was formerly head of the subscription department of the Associated Hospital Service of New York. He already has started work with the Boston organization.

N. Y. Rules Tuberculosis as Occupational Disease

Tuberculosis was ruled an occupational disease of nurses by the New York State Industrial Board recently in a test case decision that may affect many similar cases. Nurses contracting the ailment during course of their work at hospitals were entitled to compensation under the workmen's compensation law, the court said.

The decision, which had been opposed by the city, was handed down in a suit by Mary Tanenhaus, twenty-four years old, who was forced to leave her position at Bellevue Hospital in March, 1936, because of tuberculosis and sued for compensation.

The Workmen's Compensation Board awarded her \$267 for fourteen-and-a-half weeks' disability. The city appealed this award, but the state board upheld it, and as a result the city may appeal to the appellate division of the supreme court. Heretofore tuberculosis had been considered as a hazard of the nursing profession, not an occupational disease, and not covered by the workmen's compensation act. Many similar suits already are on file.

Founds Speech Institute

Impressed with the importance of the work of the National Hospital for Speech Disorders, Lucius N. Littauer, manufacturer, philanthropist and former congressman, has presented this institution with a seven-story building at 61-63 Irving Place, New York City, which he will remodel, equip and maintain as the future home of the hospital. The institution will be expanded into the Lucius N. Littauer Institute for Speech Disorders with an adequate endowment. Mr. Littauer's expenditures on the purchase, remodeling and equipment probably will represent between \$200,000 and \$225,000.



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New York City Nurses' Eight-Hour Schedule Adds Impetus to Movement in Other Sections

With the inception of the eight-hour schedule for hospital employees in the New York City department of hospitals, further impetus has been given the movement for shorter working hours for hospital employees in all sections of the country.

More than 600 New York nurses—all that could be spared from city institutions which employ 5,000—attended the celebration at 6 a.m. on July 1, the day the new schedule went into effect, to hail what they termed the addition of fifteen years to their professional lives.

"A nurse has been old at thirty-five, but with the eight-hour day we hope a nurse won't be old until she's fifty," said Lucille McGorkey, president of the Association of Hospital and Medical Professionals of the A. F. of L., which sponsored the breakfast. Other speakers were Mayor F. H. LaGuardia and Emil Ludwig, the eminent biographer.

As a result of the shortened hours, Dr. S. S. Goldwater, hospital commissioner, said the city will employ 1,281 more nurses, including the 151 employed locally on the WPA.

All Workers Benefit

Those who benefited by the reduction in hours, Doctor Goldwater said, include orderlies, ambulance drivers, attendants and kitchen, dining room and general house help.

"Only ten miles away, but four hours ahead," is the way one union circular over in Jersey referred to the New York innovation. A shortage of graduate nurses in Newark hospitals was precipitated by the New York hour reduction, and both the C.I.O. and the A. F. of L. units were attempting to organize nurses with the eight-hour day as a talking point. One hospital in Newark was said to be considering putting the eight-hour schedule into effect "all the way through" while others declared it a financial impossibility.

At Champaign, Ill., it was stated that the new eight-hour day, forty-eight-hour week law for women, passed by the state of Illinois, will not affect nurses and hospitals. Most hospital officials said they already were complying with the law, and if anything, it only would necessitate rearranging their schedules.

The American Nurses' Association recently reported it has helped secure the eight-hour day for private duty nurses in more than 850 hospitals in forty-one states. The nursing association, however, does not at this time recommend nurse membership in unions. It further states that reports of professional registries, submitted to the A. N. A. headquarters monthly since June, 1934, indicate that calls for nurses on the eight-hour schedule in-

creased in these registries from 24 per cent in 1934 to 62 per cent in 1936, while calls for nurses on the twelve-hour schedule decreased from 65 per cent in 1934 to 29 per cent in 1936.

A forty-eight hour week for nurses was inaugurated recently in Great Britain by the Victoria Memorial Jewish Hospital, Manchester, by increasing the staff of fifty-one nurses by approximately fifteen or twenty. Sir Kingsley Wood, minister of health, visiting the hospital to lay the foundation stone of the new nurses' home, commended the hospital for the step it had taken.

Dietitians Announce Plans for Meeting in Virginia

A four-day session supplemented by a two-day sight-seeing tour through historic Virginia comprises the program of the American Dietetic Association meeting to be held in Richmond, October 18 to 21.

Dr. Howard Odum, director of the Southern Institute for Social Science Research, will be a speaker on Monday, the opening day. On Tuesday, Dr. E. V. McCollum of Johns Hopkins University will speak on "Recent Developments in the Field of Nutrition," and Dr. W. T. Vaughan on "Newer Developments in the Diagnosis and Treatment of Food Allergy." Dr.

James S. McLester of Birmingham, Ala., also will speak on Tuesday. Tuesday evening the bicentennial pageant will be held at the Mosque Theater in Richmond.

The highlight of Wednesday's program will be the pellagra symposium at which Dr. W. H. Sebrell, U. S. Public Health Service; Dr. W. J. Dann, Duke University; Dr. T. Spees, University of Cincinnati School of Medicine, and Dr. D. T. Smith, Duke University, will speak. Dr. W. T. Sanger, president of the Medical College of Virginia, also will speak on Wednesday.

On Thursday there will be an evening of Southern folk lore, and on Friday a trip to Williamsburg and an address by Dr. John Stewart Bryan, president of William and Mary College. A visit to Charlottesville, the University of Virginia campus, Monticello and Ashlawn, and a colonial costume tea comprise the Saturday entertainment.

Estimates Nursing Shortage

A shortage of approximately 250 nurses in Philadelphia hospitals has been estimated by John N. Hatfield, superintendent of the Pennsylvania Hospital and executive secretary of the Hospital Association of Pennsylvania. His present forecast is that it will take at least three years to restore the balance in employment. In such hospitals as the University, Graduate, Pennsylvania and Jefferson there is a shortage of from fifteen to thirty in each institution.

London, Paris Middle Class Wage-Earners to Receive Hospital Care in New Structures

Hospitalization for middle class wage-earners whose means do not permit the expense of care in private hospitals is being provided in two of the world's largest cities—London and Paris—by erection of two new hospitals.

To provide hospitalization for the large mass of British workers with salaries in the \$1,250 to \$2,500 class, St. Bartholomew's Hospital, London, proposes to erect a special ward block adjoining the hospital to be run as a financially separate entity but to enjoy all the advantages and services that a large hospital offers. Persons of moderate means can be treated for a modest charge and services of the eminent physicians and surgeons of the hospital will be available to all patients.

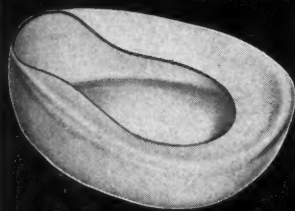
For some years the governors of St. Bartholomew's Hospital have realized the need for some provision for this class, but they are precluded by the terms of the hospital charter from ap-

plying any of its funds for this purpose. It is proposed to raise a capital sum of about \$600,000 for the erection and equipment of the building.

One of the chief objectives of a new eleven-story hospital in Suresnes, one of the densely populated suburbs of Paris, is to provide hospital facilities for members of the liberal professions and middle class wage-earners. The hospital, which is nearing completion and was to be called the Foch Foundation, will be known as the "Medical Foundation of Mount Valerian." The change in name was made to avoid confusion with a hospital in Paris for wounded veterans termed "Foch Hospital."

The honorary president of the Medical Foundation of Mount Valerian is the widow of Marshal Foch, but the president of the ladies' auxiliary, which deserves credit for the major portion of the work of building the new institution, is Mrs. Jacques Balsan (née Vanderbilt).

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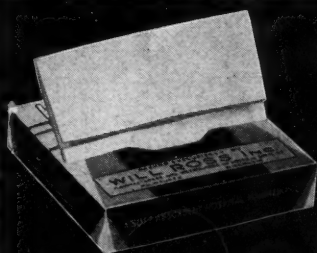
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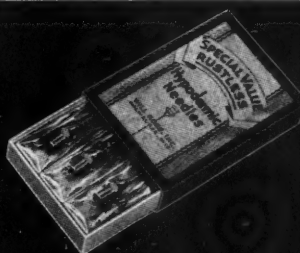
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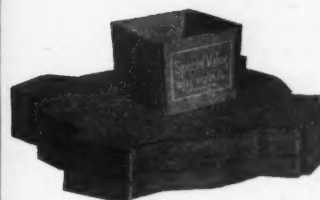
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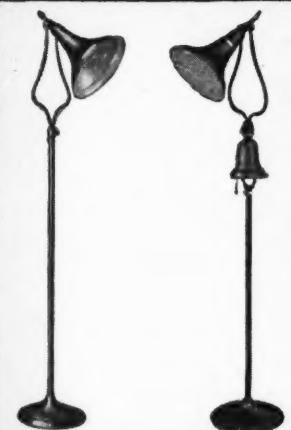
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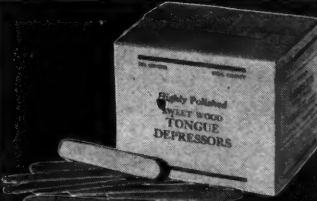
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Hospital Service Classification Suggested as Means of Financial Aid at Manitoba Meeting

Increased financial aid for Canadian hospitals through legislation was discussed at the annual meeting of the Manitoba Hospital Association in Brandon, June 24 to 25, held in conjunction with the Manitoba Association of Registered Nurses. It was suggested that the provincial government be asked to classify hospitals in accordance with the standard of service with a view to obtaining higher ward rates and government grants for metropolitan hospitals.

Contentious interpretations of the Hospital Aid Act were explained by Dr. E. W. Montgomery of the Department of Health and Public Welfare, dealing specifically with difficulties of establishing residence for municipal cases and payment for extra provincial public ward cases.

A resolution was adopted instructing the executive of the Manitoba Hospital Association to endeavor to establish better cooperation between the hospital association, the Manitoba Medical Association and the Union of Manitoba Municipalities in connection with legislation respecting hospitals. This was brought about upon the motion of Dr. J. F. Clingham, representing the Manitoba Medical Association, who said that under the terms of the Hospital Aid Act, it was possible for municipalities to have residents cared for in city hospitals with liability only for payment of statutory rates. In some instances, he said, these patients

were considered to be in a position to pay higher rates, and also to pay the attending doctors. Doctor Clingham believed this should be brought to the attention of the municipalities.

To meet added expenditures of the Manitoba Hospital Association entailed through providing support of the Canadian Hospital Council, it was suggested that the provincial and federal hospitals in the province should be requested to become members of the association and contribute toward its support, since both of these types of hospitals are benefiting through activities of the association and the Canadian Hospital Council. Failing in other measures to secure income, it was the feeling of the convention that the hospitals would be willing to pay a higher membership fee.

The afternoon session on June 24 was under the chairmanship of the Manitoba Association of Registered Nurses, dealing with nursing curriculum papers. At the annual dinner that evening, the Hon. E. A. McPherson, K.C., spoke on "The Relation of the Municipality to the Hospital."

Friday morning was given over to a hospital dietetics section. The official business of the association was closed at noon, and during the afternoon the delegates visited the Brandon Mental Hospital.

Dr. G. S. Williams of the Children's Hospital of Winnipeg was reelected president of the Manitoba Association.

California Group Blocks County Hospital Measures

Legislation introduced into the last session of the California state legislature proposing to open county hospitals to pay patients was defeated through efforts of the Association of California Hospitals.

Four measures proposing to open city and county institutions were abandoned by the legislature when it was shown by the association that such legislation would result in increased tax burdens, and that the person of moderate means can more easily and economically budget for hospital care under nonprofit hospital service plans.

Bulletins were issued by the association to its members keeping them informed of all legislative activities. A digest of proposed and new laws passed by legislatures of the Western states is being prepared by the association.

Wrecks Equipment

A cloudburst at Sandusky, Ohio, which washed out all existing records for rainfall, flooded the basement of Providence Hospital, destroying x-ray and other equipment, along with medical stores. Damage was \$30,000.

Campaign for Expansion

St. Vincent's Hospital in Erie, Pa., is conducting a limited fund-raising campaign during the summer months to finance a \$500,000 expansion program. A sixty-five-bed maternity hospital building, a separate laboratory building, which also will house a urologic clinic, and replacement of the present power house and laundry comprise the three parts of the hospital's program. During extended periods last winter and this spring, all hospital beds in Erie were occupied and doctors were forced to delay the hospitalization of many nonemergency cases. The new units planned will provide adequate hospital facilities for Erie.

Sympathizes With Strikers

A director of the Jewish Hospital of Brooklyn, Louis T. Strauss, has resigned because of his sympathy with the strikers of the Hospital Employees Union. Mr. Strauss is the proprietor of a meat market. In accepting his resignation, Nathan Honas, president of the hospital, said that Mr. Strauss' market had been picketed and this was the real reason for the resignation.

Late Figures Reveal Gain in British Columbia Vote

The latest available figures on the health insurance plebiscite recently held in British Columbia were 116,223 in favor of health insurance and 80,982 against it, even a greater majority than was anticipated when the returns first started coming in during June.

That it would be unwise for a single province to embark on a scheme of health insurance independently of the other provinces and the Dominion was an opinion expressed in the recently presented report of the industrial relations committee of the Canadian Manufacturers' Association. The sound method of procedure was held to be provincial cooperation under federal supervision.

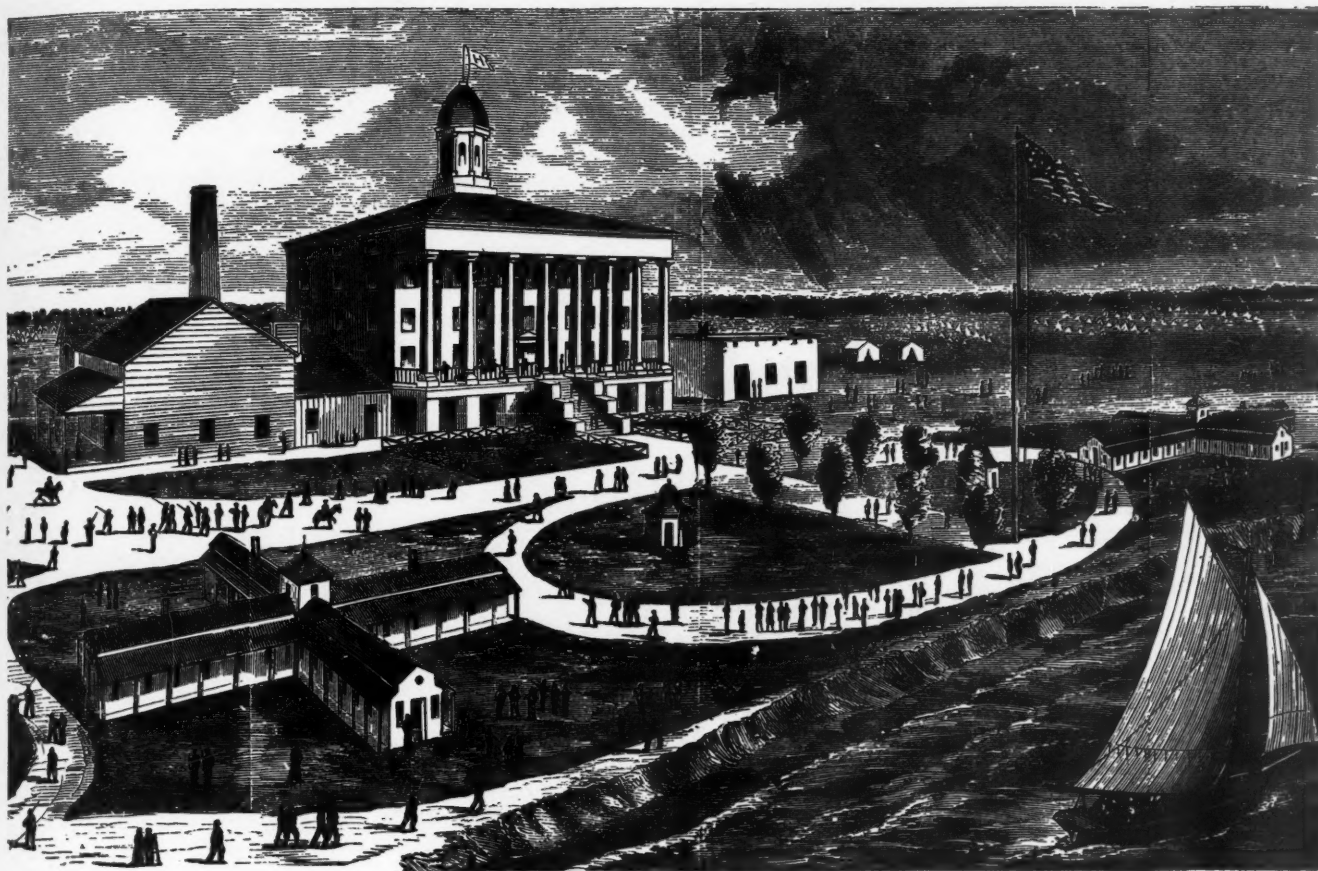
Starts Proceedings

St. Francis Hospital, Pittsburgh, started mandamus proceedings recently to compel state officers to pay to the institution \$156,250 which was appropriated by the 1935 legislature, but which, the hospital claims, was never paid by the state. The action is directed against the state treasurer, state auditor and secretary of welfare.

Coming Meetings

- Colorado Hospital Association.**
Next meeting, Pueblo, Aug. 12.
- National Hospital Association.**
Next meeting, St. Louis, Aug. 15-17.
- Hospital Institute.**
Next meeting, University of Chicago, Aug. 30-Sept. 10.
- Canadian Hospital Council.**
Next meeting, Ottawa, Sept. 8-9.
- National Association of Nurse Anesthetists.**
Next meeting, Atlantic City, N. J., Sept. 14-16.
- American College of Hospital Administrators.**
Next meeting, Atlantic City, Sept. 12-17.
- American Hospital Association.**
Next meeting, Atlantic City, Sept. 13-18.
- American Protestant Hospital Association.**
Next meeting, Atlantic City, Sept. 10-12.
- Children's Hospital Association.**
Next meeting, Atlantic City, Sept. 13-17.
- American Public Health Association and National Organization for Public Health Nursing.**
Next meeting, New York City, Oct. 5-8.
- Saskatchewan Hospital Association.**
Next meeting, Regina, Oct. 10.
- American Dietetic Association.**
Next meeting, Richmond, Va., Oct. 18-21.
- Ontario Hospital Association.**
Next meeting, Toronto, Oct. 20-22.
- American College of Surgeons.**
Next meeting, Chicago, Oct. 25-29.
- Association of Record Librarians of North America.**
Next meeting, Chicago, Oct. 25-29.
- Kansas Hospital Association.**
Next meeting, Newton, Oct. 30.
- Colorado Hospital Association.**
Annual convention, Denver, Nov. 9-10.
- Alberta Hospitals' Association.**
Next meeting, Edmonton, Nov. 15-17.

Even During The Civil War Days *Hospitals Depended on Webb's Alcohol*



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[With "comforts generally vastly greater than could possibly be enjoyed at home," the Chesapeake hospital located at Old Point Comfort won for itself a peerless reputation. It rose three stories above a lofty basement and looked "upon a harbor which has scarcely a rival on this globe."]

IN 1864 alcohol was already one of the most vital requirements of hospitals. Practically no item in the apothecary steward's stock came into more frequent use. Scores of tinctures, drugs and extracts were made standard, rendered constant in potency and preserved in alcohol.

Probably no alcohol was more widely used in 1864 than Webb's. Hospitals knew, for instance, that James A. Webb and Son had been making the highest quality alcohol since 1835—29 years before 1864. The Webb brand could truly be called the standard of quality.

In 1915, the U. S. Industrial Alcohol Co. acquired James A. Webb & Son and the famous Webb brand of alcohol. To the eighty years' experience of the Webb

family was added the vast technical resources of U.S.I.

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NAMES IN THE NEWS...

DR. ALBERT W. SNOKE will succeed DR. JOE R. CLEMMONS as assistant director of Strong Memorial Hospital, Rochester, N. Y., when Doctor Clemmons leaves on September 1 to be director of Roosevelt Hospital, New York City. Doctor Snoke was graduated in 1933 from the Stanford University school of medicine, and has been a member of the resident staff of Lane-Stanford Hospital, San Francisco, and of Strong Memorial Hospital.

MRS. GAIL P. CARLEY of New York City is the new superintendent of the Ellsworth Municipal Hospital, Iowa Falls, Iowa. Mrs. Carley is a graduate of the Connecticut College for Women, receiving the B.S. degree in 1922 and the M.S. degree in 1926. She also has studied at the Yale Medical School and School of Public Health, and has taken extensive work in hospital administration.

ROBERT S. HUDGENS, assistant superintendent of Emory University Hospital, Emory University, Ga., since 1929, has been promoted to the position of superintendent. Mr. Hudgens succeeds Dr. Russell H. Oppenheimer, who for the last twelve years has been superintendent of the hospital, as well as dean of the Emory School of Medicine, and who has been named to the new position of medical director of the hospital. Mr. Hudgens has won recognition as a hospital administrator in the Southeast, being past president of the Georgia Hospital Association, secretary of the Southeastern Hospital Association and member of the American College of Hospital Administrators.

H. GRACE FRANKLIN, R.N., graduate of the New York City Hospital School of Nursing and with postgraduate work at the New York School of Philanthropy, New York Health Department and Columbia University, has launched a service for medical personnel and medical institutions in Los Angeles. Every member of her organization is medically trained.

DR. H. M. FRANCISCO will be succeeded as superintendent of the Eastern State Hospital, Knoxville, Tenn., by DR. O. S. HAUKE, superintendent of the Tennessee Home and Training School for Feeble-Minded, Donelson, it has been reported by the *Nashville Banner*. It is also reported that DR. C. D. LEE, assistant to Doctor Hauke, would be named as his successor at the Feeble-Minded Institute.

MAE H. FYE, formerly superintendent of the Franklin Square Hospital, Baltimore, is the new superintendent at Virginia Municipal Hospital, Virginia, Minn., succeeding CHARLOTTE JANES GARRISON.

WILSON L. BENFER, thirty-one, has assumed his duties as superintendent of Toledo Hospital, having become head of the hospital upon recent action of the trustees. Following the death last January of G. W. WILSON, who had been superintendent more than six years, Mr. Benfer was appointed acting head. He is said to be one of the youngest superintendents to head a metropolitan hospital, having been associated with the Toledo Hospital nine years.

DE MOSS TALIAFERRO, superintendent of the Rockford Hospital, Rock-



De Moss Taliaferro

ford, Ill., became director of Denver's Children's Hospital on August 1, succeeding ROBERT B. WITHAM, who resigned two months ago. Before going to Rockford, Mr. Taliaferro was superintendent for nine years of the Cottage Hospital at Galesburg, Ill.

V. T. ROOT, business manager of the Methodist Episcopal Hospital, Gary, Ind., has been appointed superintendent of the Rockford Hospital, Rockford, Ill., effective August 1.

DR. GEORGE FREDERICK CLOVER, pastor and former superintendent of St. Luke's Hospital, New York City, died at his summer home in Connecticut recently at the age of seventy-one. Doctor Clover was president of the Hospital Conference of Greater New York from 1906 to 1915.

ADELIN NELSON is the new chief record librarian at St. Mary's Hospital, Kankakee, Ill., having just completed the course in medical records at St. Mary's Hospital School for Medical Record Librarians, Duluth, Minn.

DR. HERBERT S. GASSER, director of

the Rockefeller Institute for Medical Research, has been elected a trustee of the Rockefeller Foundation.

DR. RAYMOND G. WEARNE, for the last seven years assistant superintendent at the Central Islip State Hospital, Long Island, N. Y., was appointed superintendent of the Wassaie State Hospital recently to succeed DR. HARRY C. STORRS, who upon his own request has been transferred to Letchworth Village State Hospital, Thiells, N. Y.

MRS. AGNES D. ROBERTS, who has been proprietress of the Brockport Central Hospital, Brockport, N. Y., since May, 1932, has tendered her resignation to the Hospital Aid Association. If accepted by the association, the resignation will become effective upon the termination of Mrs. Roberts' contract, September 1.

DR. EDMUND F. COLLINS was elected to succeed DR. WARREN L. BABCOCK as superintendent and director of Grace Hospital, Detroit, recently by the board of trustees. Doctor Babcock's retirement becomes effective October 1.

DR. ALFRED R. SHANDS, JR., professor of surgery in charge of orthopedics at the Duke University School of Medicine, Durham, N. C., has been selected as the resident physician of the proposed Nemours Foundation, near Wilmington, Del., a home and hospital for crippled children, established by the late Alfred E. du Pont in his will. The selection of Doctor Shands is regarded as indication that plans for the hospital and home are progressing rapidly, looking to an early start on the construction.

AGNES GRAY has assumed the superintendency of the Memorial Hospital of Reidsville, N. C., succeeding the late LELA FISHER, who died early in the spring. Miss Gray formerly was superintendent of nurses at Park View Hospital, Rocky Mount, N. C.

ARCHIE J. ALLEN of Chico, Calif., has been elected superintendent of the Butte County Hospital, Oroville, Calif., replacing J. F. McDONALD, who has held the post for fourteen years and whose term expired in January.

DR. JOHN D. FULLER will succeed MRS. FAITH B. SHAW, for the last six years superintendent of the Santa Cruz County Hospital, Santa Cruz, Calif. In addition, he will be full-time Santa Cruz county physician and health officer.

JEWEL SEALE, R.N., has accepted the superintendency of the Meridian Sanitarium, Meridian, Miss.

ESTHER WOLFE, R.N., superintendent of the Hutchinson Community Hospital, Hutchinson, Minn., for the last three years, has resigned to become superintendent of the St. Andrew's Hospital, Minneapolis, replacing REBECCA PETERSON, who retired June 15.

SISTER M. BORGIA of Ironwood, Mich., has been appointed superior of Good Samaritan Hospital, Zanesville, Ohio, taking the place of the present superior, SISTER M. EDNA.

Is Your Hospital Paralyzed?

Are your efforts to furnish adequate service to your community restricted by insufficient buildings, lack of proper equipment, or the menace of growing deficits?

If your hospital faces any one of these situations, your board needs without delay the counsel of a firm thoroughly versed in philanthropic finance.

Ward, Wells & Dreshman have behind them a quarter century of experience in raising funds for hospitals, institutions of learning, churches and community enterprises. We have successfully financed more than 250 hospitals—a record unequalled in this field. This remarkable accomplishment is the result of tested methods originated and developed by this firm.

A Ward, Wells & Dreshman campaign director is a man of proven ability and forceful personality. He has an established record in meeting obstacles that stand in the way of success. Let a member of our staff discuss your problem with you, without obligation. Write us today.

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DR. DONALD W. TRIPODI has resigned as superintendent of the Livingston County Sanatorium, Pontiac, Ill., to engage in private practice in St. Louis.

FLOSSIE GAMBLE has been appointed superintendent of the Whitfield Lisenby Hospital, Panama City, Fla., to succeed GRACE CRUTCHFIELD, who recently resigned. Miss Gamble has been associated with the Frasier-Ellis Hospital, Dothan, Ala., since it was founded.

DR. D. M. ALDERSON is the new superintendent of Mount Airy Hospital, Denver.

NELLIE L. BLOXHAM, superintendent of the Day-Kimball Hospital, Putnam, Conn., for the last twenty years, has retired. ANDREW K. FULKERSON, business manager of the hospital for the last three years, was appointed acting superintendent until the annual meeting of the trustees, at which time a permanent head of the institution will be named.

ETHEL M. SWOPE, since 1933 assistant director at headquarters of the American Nurses' Association, with special assignments in field work for the organization, died recently of leukemia at Washington, D. C. Miss Swope was a graduate of the Connecticut Training School for Nurses, New Haven.

DR. KARL M. BECK became county physician and superintendent of the Lake County General Hospital, Waukegan, Ill., for two years on July 1.

DR. CLYDE MILLER, a former intern at Wesley Hospital, Wichita, Kan., recently was named superintendent of the Sedgwick County Hospital, Wichita, by the board of commissioners to succeed DR. H. O. ANDERSON.

MINNIE B. RETZLOFF recently tendered her resignation as superintendent of Natrona County Memorial Hospital, Casper, Wyo. It was expected that MARY ANN ESCHWIG, private nurse, would be named to the superintendency of the hospital.

DR. ALFRED E. A. HUDSON of Goldsboro, N. C., has been appointed acting administrator of the new Waynesboro General Hospital, Waynesboro, Va., which is expected to open by August 15. Doctor Hudson is assisting in the purchasing and installation of equipment in an advisory capacity. The new structure is a three-story brick building.

DR. ROLLIN D. THOMPSON, medical director and superintendent, Wisconsin State Sanatorium, Statesan, has been placed in charge of the new state tuberculosis sanatorium at Orlando, Fla.

MRS. GRACE W. MYERS, honorary president, the Association of Record Librarians of North America, is convalescing at her home in Brookline, Mass., from a bone fracture suffered in an accident.

DR. CHARLES R. LOWE, superintendent of the State Hospital South, Blackfoot, Ida., since 1930, has been appointed director of the Nampa State School and Colony to succeed DR. D'ORR POYNTER, who resigned after several years in that position.

MRS. E. B. LAMAR is the new superintendent of Aiken County Hospital, Aiken, S. C.

LEONA J. BOHACH, R.R.L., of St. Luke's Hospital, N. Y., is the new head record librarian of the Syracuse Memorial Hospital, Syracuse, N. Y. She succeeds the late MRS. PAULINE COCKLINGS.

BARBARA STEPHENSON of Winters, Calif., has been appointed to succeed MRS. ELEANOR LAFFERTY, who resigned as superintendent of the Colusa County Memorial Hospital, Colusa, Calif. Miss Stephenson formerly was employed at hospitals in Arbuckle, Woodland and Sacramento, Calif.

WILL W. WOOD, business manager for the last ten years of the Valley Hospital in Klamath Falls, Ore., has leased the Ashland Community Hospital, Ashland, Ore., and has assumed the superintendency of that institution.

ELEANOR SLACUM has been elected superintendent of the Cambridge-Maryland Hospital, Cambridge, Md., succeeding MARTHA E. WRIGHT, who resigned. ELIZABETH ENGELMAN will be assistant superintendent.

DR. J. D. CARR, superintendent of the North Dakota State Hospital for the Insane, Jamestown, has resigned. HENRY G. OWEN, Grand Forks attorney, has been appointed acting superintendent.

THRESSA BELKNAP, nursing superintendent of the Sarnia General Hospital, Sarnia, Ont., has resigned to accept a similar position in a hospital in Columbus, Ohio.

READER OPINION

Reopen City School

Sirs:

The statement in the July issue of *The Modern Hospital* that 1,200 nurses had been imported from other states by Dr. S. S. Goldwater, commissioner of hospitals, in order to put into effect the eight-consecutive-hour-day in New York City hospitals reveals a curious and contradictory state of affairs in New York. Not long ago we were told that there was an over-supply of nurses in New York State, and many excellent schools were discontinued in order to reduce the number of nurses graduated each year. The Department of Hospitals itself disbanded the city hospital school of nursing, one of the oldest and best known schools in the country about five years ago.

Doctor Goldwater attributed the shortage to the eight-fold increase in the required number of hospital nurses within the last thirty years, an increase with which nursing schools had been unable to keep pace. There are about twenty-six hospitals in the municipal group. Why cannot the city train its own supply of nurses? It is true that in some of these hospitals there is a preponderance of some particular classification of disease, but the state department of education recognizes and approves of affiliation of hospitals in order to obtain a complete training with a proper balance of the various services necessary to qualify for registration with the education department. Moreover, when we stop to consider the class of patient most frequently found in city institutions, it would seem that such hospitals would be especially suited for preparing nurses for the public health field, social service and visiting nurse work. Why not reopen the city hospital school of nursing and so prepare to eliminate the shortage of nurses in municipal hospitals in the future?

BEATRICE V. STEVENSON, R.N.
Former President.

New York State Nurses Association,
Brooklyn, N. Y.

DR. W. W. SCHWABLAND, Seattle physician and specialist in tuberculosis, who resigned last December under fire as superintendent of Morningside Tuberculosis Hospital, was renamed to the post recently. Doctor Schwabland succeeds DR. GRANT CALHOUN, named acting head at the time of Doctor Schwabland's resignation.

DR. CLIFTON SMITH, formerly a staff member of the Missouri State Hospital No. 2, St. Joseph, has assumed charge as superintendent of the St. Louis Training School, an institution for feeble-minded children, succeeding DR. GEORGE A. JOHNS, who resigned to accept a position as head of a similar institution in Baltimore. Doctor Smith spent a month last spring at the Central Islip Hospital near New York studying mental cases, and last year did postgraduate work at the Cook County Hospital in Chicago.

LENA DUKE of the Dickie Sanatorium at Southern Pines, N. C., will become superintendent of the new Wake Tuberculosis Hospital, Raleigh, N. C., it has been announced by DR. A. C. BULLA, county health officer. MRS. MOLLIE COOK, R.N., of Raleigh, has been named assistant superintendent.

DR. HENRY JOSEPH SOMMER, for twenty-eight years superintendent of the Blair County Hospital for Mental Diseases at Hollidaysburg, Pa., died recently at his home in Altoona, Pa.

MARTHA J. AVARD, superintendent of the Addison Gilbert Hospital, Gloucester, Mass., has tendered her resignation, effective August 1, upon completion of a quarter of a century with that institution.

DR. BERT MOORE, specialist in the treatment of tuberculosis, will head the new Knox County Tuberculosis Hospital at Vincennes, Ind., when the institution opens around September 1. Doctor Moore, who has been resident physician in a number of hospitals, will be both superintendent and medical director.

ETHEL REESOR, superintendent of the Charles S. Gray Deaconess Hospital, Ironton, Ohio, for the last seven and one-half years, has resigned. Miss Reesor will be succeeded by EDITH BROWN.

ANNA MALLISON, graduate nurse of the Bethany Hospital in Kansas City, Kan., succeeds ERMA REA BROWN as superintendent of the Dickinson County Memorial Hospital, Abilene, Kan.

DR. W. J. BRYAN has resigned as superintendent of the Missouri State Sanatorium at Mount Vernon, a position he has held for the last four years, to head the Rockford Municipal Sanatorium, Rockford, Ill. Doctor Bryan succeeds DR. ROBINSON BOWORTH who resigned to become superintendent of a new tuberculosis sanatorium in St. Clair County, Illinois.

DR. PAUL A. YODER, superintendent of the Forsyth County Sanatorium, Winston-Salem, N. C., was elected president of the North Carolina State Tuberculosis Association at its recent annual meeting in Southern Pines.

Board Will Save On Cost Of Water

Special Valves Installed in
High School Will Be Used
Also at Other Buildings

Two notable instances of economy in conducting affairs of the public schools were brought out Wednesday night at a meeting of the Board of Education. One was a reduction of the High School water bill from \$315.32 to \$67.38 for a quarter period—within a few dollars of \$1,000 per year saved on one school alone.

The saving was effected through Commissioner Joseph Galvanek who had installed special valves controlling the automatic flush system. A further saving will be made in the other school buildings where similar improvements are to be made.

Carteret, N. J., Press
Friday, Jan. 15, 1937

Satisfaction

plus

cash

dividends

In the clipping reproduced above, the valves installed were, of course, Sloan Flush Valves.

Sloan Valves installed in the Liverpool Building, San Francisco, about two years ago are saving \$20 a month on the water bill.

46 Sloan Valves in the Royal Insurance Building, San Francisco, save \$18 worth of water a month.

The Normandie Apartments in Seattle replaced 85 () Valves with Sloan Star Valves in 1931. Since that time the former \$95 a month water bill has averaged but \$30 a month.

In the Belleville Township High School (Illinois), 26 Sloan Valves were installed in 1932. Former water bills of \$180 to \$195 a month have dropped to \$90 or \$95 a month.

In Worcester, Massachusetts, two-thirds of the water cost of the Convenience Station in the Commons has been eliminated since the installation of Sloan Valves.

In the Lee Street School, also in Worcester, 50% of the water cost has been saved since installing Sloan Valves.

SLOAN VALVE CO. • Chicago

(The figures given above for water savings are taken from letters in our files. Photostat copies will be furnished on request.)

1. Maximum water savings cannot be obtained if the operator can cause a long or short flush. Sloan Flush Valves cannot be held open to waste water.

2. Sloan Flush Valves are self-cleaning, preventing waste of water from clogged valves failing to shut off.

3. Sloan Flush Valves will give efficient service on any pressure that will operate the fixture.

4. Sloan Flush Valves are the only ones to combine accurate regulation with the non-hold-open feature.



SLOAN FLUSH VALVES

LITERATURE in ABSTRACT • • •

Conducted by E. M. Bluestone, M.D. and Joe R. Clemmons, M.D.

Electric Air Cleaning

Already air conditioned to the extent of temperature and humidity control, the lower arcade and first four floors of the Field Building, Chicago, is to install electrostatic air cleaners.* The air cleaning equipment will have a capacity of 272,700 c.f.m. of air and an expected efficiency of over 99 per cent by weight of particles removed from the air. The air cleaner is said to remove microscopic particles as small as one-fifth micron in size, to operate on a small current consumption of 10kw. and a minimum of maintenance.

The equipment ordered will consist of eighteen units ranging in capacity from 33,000 c.f.m. to 3,000 c.f.m., employing a total of 369 collector cells and 185 ionizing assemblies.

*Unsigned, *Cleaning Air with Electricity, Heat, and Vent.*, 34: 70 (May) 1937. Abstracted by Joe R. Clemmons, M.D.

Five Beds for Four Patients Adequately Flexible

The committee on hospital planning and equipment of the American Hospital Association (1935) dealing with overhospitalization advanced the theory that three beds for every two patients were too many.*

A general hospital, given a flexible building and less rigid policies in the grouping of patients, should handle its work effectively with five beds for every four patients, or a reserve of 25 per cent instead of 50 per cent. In 1934, 4,000 general hospitals reporting to the American Medical Association had 87,500 beds in excess of such 25 per cent reserve and this surplus cost the public in fixed charges approximately \$61,250,000—a sum sufficient to have paid for the care of nearly one-fifth of all patients treated that year.

A general hospital should be able to handle its work if it has one reserve bed for every four patients in its average daily census.

The days of peak load in occupancy are figured at 120 per cent of the average census for the year (when 98 per cent of the beds, given a 25 per cent reserve would have been occupied) and the maximum at 125 per cent when every bed would have been filled and perhaps a few extra beds set up in solariums or in some other spot used for overflow.

From daily census records of twenty-four hospitals for the years 1934-36

reviewed in detail, many interesting and significant facts emerge.

1. Hospitals that operate at relatively high average capacity have fewer days of high census.

2. The hospitals of smaller capacity experience have wider fluctuation than larger ones.

3. Peaks occur in every month of the year but are most prevalent in March, April and May.

4. The number of days on which hospitals are crowded are few in comparison with the large portion of reserve beds carried.

These statistics are confined to post-depression years and further study should extend to depression, normal and prosperity periods. General occupancy figures, such as those here used, unquestionably conceal many internal fluctuations in the different departments.

1. Hospitalization is probably one of the most stable of all this country's industries. -

2. The nation's investment in general hospitals averages \$5,000 a bed, with annual fixed charges at \$750 (\$250 for interest, \$150 for depreciation and \$350 for "readiness to serve" cost).

3. The record of general hospital bed occupancy by states for 1935 reveals only seven states with an occupancy of 70 per cent or more.

4. More than one-half million beds are now being maintained in this country in nongovernment hospitals and notwithstanding about 145,000 idle beds in 1935, new beds are being added at the rate of seventy-seven each day according to statistics for the year 1936 compiled by the council of medical education and hospitals of the American Medical Association.

The chronic malady of overhospitalization appears to be due largely to the following causes:

1. Hospitals have failed to pool their resources. Although hospital care is financed out of the community purse, it is rarely approached as a common problem.

2. The methods long used to estimate the needs of a given district or a given hospital appear faulty. Most disastrous has been the lack of any curb on the ambitious hospital that builds without regard to facilities already available or appraisal of the volume of work to be done in the community.

3. The individual hospital is frequently unable to pool its reserve beds because of a lack of elasticity in plan and policy. Each department has its

own quota of beds and maintains its own reserve.

4. Empty beds are deliberately maintained for causes or possibilities that should be disregarded or given minor position under existing conditions. When a disaster occurs emergency hospitals are set up in other buildings. Redecoration should never be permitted to keep needed beds out of service.

5. Too much attention is given to the tradition that an average occupancy of 80 per cent is the saturation point and a new wing should be started.

6. The modern trend is toward less care of patients in general nongovernment hospitals.

Three steps are suggested in remedying the situation.

1. An estimate of the future average census and a factor of safety set up to take care of the overloads.

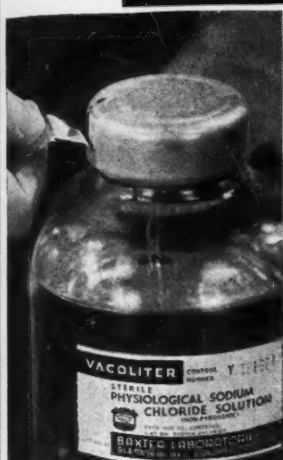
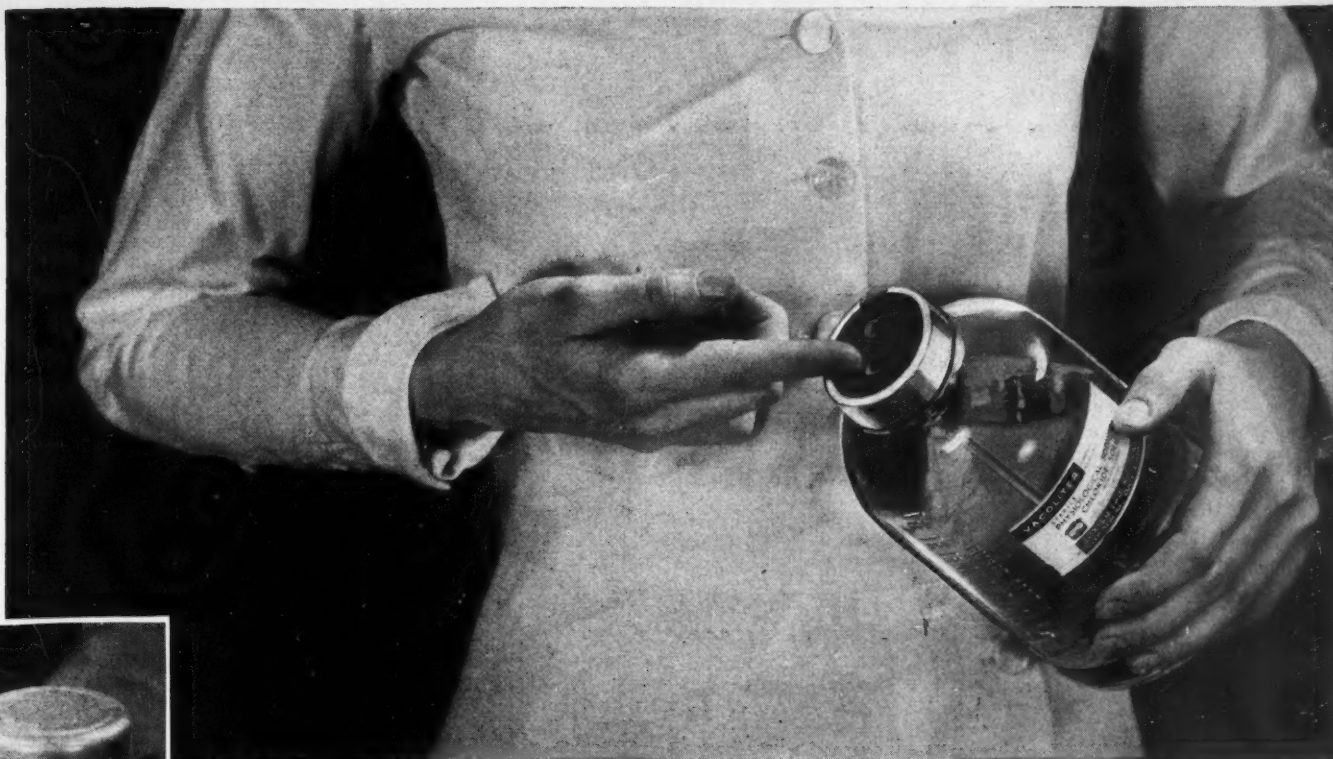
2. The necessity for additional hospital beds in any locality should be proved from the standpoint of the community as a whole on the basis of the utilization of existing beds over at least five preceding average years with particular reference to the ability of the staff to fill any proposed new beds. Probable occupancy curves on each basis, conservatively forecast, should be plotted and then harmonized. The final curve will more accurately indicate the number of required beds than any previously accepted formula.

3. The third method, to show by graphs the demonstrated need, department by department, following the principle that five beds to every four patients is sufficient for normal needs. Any construction beyond that is extravagant.

The outstanding experience of a 100-bed general hospital in New York City illustrates what can be done. It was perhaps the first institution in the country to be deliberately designed to take care of peak loads through a flexible plan with single rooms, small wards and solariums on all floors arranged to accommodate twenty additional beds when needed. During five consecutive years prior to the depression, its annual census averaged from ninety-one to ninety-nine patients a day, and this without material inconvenience or overcrowding. The financial results were particularly significant; the revenue from patients in those years approximated operating expenses. With overhead costs spread over capacity occupancy, a greater proportion of earnings could be spent for the refinements of service. The benign circle for successful business was set in motion.

Quality promoted volume and volume with flexibility reduced costs.

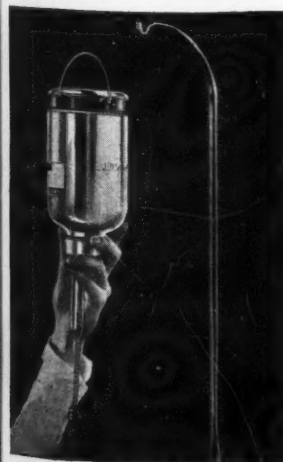
*Neergaard, Charles F.: *How Many Hospital Beds Are Enough?* J. A. M. A. 108: 1029 (Mar. 27) 1937. Abstracted by Joe R. Clemmons, M.D.



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CHICAGO

NEW YORK

Outsider's Viewpoint

"Shall we engage talent from outside our organization to advise with us in the solution of our problems?" The answer depends upon the personnel of the organization, the nature of the problem and services available.*

Consulting services may be divided into three groups: technical, methods and management. Technical advisory services call for the type of specialists not usually found in the average organization. There is no question as to the advisability of utilizing specialists in these fields.

Between the technical field and organization and management is the zone of office methods, production and routines which has attracted an army of efficiency experts, and "engineers," offering to sell savings at so much per diem or by the job. It is here that management must be most cautious. Changes can be "railroaded" through by dictation, but intelligent and willing cooperation is necessary for their ultimate success. Major changes in operating procedure should be made no faster than the organization is able to assimilate them.

A successful plan consists of expert advice and guidance, depending upon one or more competent men to carry out the details of the recommended changes. The outside viewpoint of a reputable expert does enable constructive changes to be instituted. This procedure provides excellent training and experience for the staff planning men who should, in time, become "experts."

Management consulting service concerns itself with policies and sometimes personnel. Various associations and other media for the exchange of experiences provide an adequate substitute for this form of service.

*Unsigned, Shall We Engage a Consultant? *Genesee Valley Buyer*, 14: 19 (Dec.) 1936. Abstracted by Joe R. Clemmons, M.D.

Urges Central Heating

Summarization by the United States Bureau of Mines of the explosion at the Consolidated School Building, New London, Texas, was given to Governor James V. Allred of Texas, by Acting Secretary of the Interior Charles West.*

The following recommendations were made:

1. Basements, attics and buildings in which the public assemblies should be provided with adequate, constantly functioning ventilation.

2. All gas and electrical lines, piping connections, fixtures, appurtenances, and appliances should be of permanent construction, placed in accordance with the latest approved fire underwriters' specifications and should be kept in repair at all times.

3. Responsibility for construction, maintenance and operation of gas pipe

lines and the regulation of pressure in such lines, should be under the control of those experienced in such work. Responsibility for testing and general care of such systems should be entrusted to competent persons.

4. Gas mains or heaters outside of buildings minimize the hazard of gas leakage in enclosed spaces.

5. The explosion at the school was not attributable to seepage of gas through the soil. Gas may enter basements and other enclosed spaces; consequently, all openings where pipes pass through walls should be sealed.

6. Central heating systems have definite advantages with respect to protection against fire, explosion and carbon monoxide.

7. Warning agents with distinct odors introduced into fuel gases are of great aid in detecting leaks. Warning devices based on instruments to be effective must be maintained carefully and tested frequently.

8. Careful inspection by state and municipal agencies as to structural as well as heating and ventilation features in buildings in which the public assemblies is needed.

*Unsigned, Bureau of Mines Reports on School Disaster; Urges Central Heating Plants in Isolated Structures, Heat, and Vent., 34: 69 (May) 1937. Abstracted by Joe R. Clemmons, M.D.

Join or Not Join

"Why is it," John L. Lewis asked, "that after fifty-five years of effort, out of a total of 39,000,000 wage earners open to solicitation, the American Federation of Labor has made members out of only a scant 3,500,000?" Mr. Lewis answers this question but no dispassionate observer can agree with the factors he proceeds to name and blame as responsible—the excessive and inactive pride of office, the lazy autocratic oversecurity of official position demonstrated by all the heads of the established craft unions. It is well known that few labor leaders anywhere enjoy the autocratic power of Mr. Lewis and his fellow officers.*

Is it possible to be satisfied with his over-simple explanation that fear of employers is also a factor. Instead, the explanation is found in the fact that most of the nonjoiners haven't wanted to join. They insist on sizing up the matter, not as a class affair, but instead, on small items weighed on the scale of personal daily experience.

"If I join, what do I get for my money?" Here the organizer meets his greatest challenge. The threat of personal injury to the nonmember's family, the unimaginable power of all the mass pressure exerted on the calmer ones during any strike, the continued urging of national radio drives can persuade many a good citizen worker to pay his initial fee. Only one thing can keep him paying those dues month after month. That is his

recognition of unquestioned value received in the satisfactory handling of his individual grievance.

It is this important individual grievance which offers to the employer the opportunity to compete with the labor leader on equal terms. The American worker is slightly concerned as to whether improvement of his condition is obtained by means of a belligerent labor leader or an intelligent, far-seeing cooperative employer. Both of these competitors must perforce meet the acid test of his hard boiled Yankee query: "Well, let me look at my experience."

*Williams, Whiting: Extracted from Today, article entitled, Union, Disunion, Reunion, *Gen. N. Y. Purchaser*, 7: 27, (Jan.) 1937. Abstracted by Joe R. Clemmons, M.D.

Coal Yardstick

Approximate analysis of coal is a yardstick which gives the coal operator a check on quality of his product and the buyer a guide by which to work. Proximate analyses are made on "as received," "as fired" or on a "dry basis." Determinations should represent averages taken over a period of time under uniform conditions.*

Coal from major producing areas is well established as to general type so that in considering an analysis given by a mine, it can be checked with other claims for the same area, making due allowance for special preparation or mining methods. It is wise for the buyer to ascertain that the figures submitted represent the size of coal that he buys.

The component parts of a proximate analysis are:

1. Moisture, *e.g.* the amount of inherent and surface water in the coal. It is a waste product.
2. Volatile matter, which includes the combustible gases—hydrogen, carbon monoxide, methane and other hydrocarbons.
3. Fixed carbon, a rather loose term generally applied to that remaining after moisture, volatile matter, ash and sulphur are accounted for.
4. Ash, the inherent, solid, noncombustible impurity remaining after the fuel is burned.
5. British thermal unit, (B.t.u.) is the amount of heat required to raise one pound of water one degree Fahrenheit.
6. Fusion temperature, the lowest temperature at which ash will flux and form clinker or slag.
7. Sulphur, the amount of organic sulphur present.

Most buyers of coal set up an accurate coal cost, cost per thousand pounds of steam being one of the most familiar. Analyses are used as a primary check on coal.

*Biggs, J. M.: Digest of Talk on Coal, *Genesee Valley Buyer*, 14: 15 (Dec.) 1936. Abstracted by Joe R. Clemmons, M.D.



M. BURNEICE LARSON
DIRECTOR

*.... and we'll find them and
we'll send them on to you*

When you take "pen in hand" to write to us to find a man, a woman you want, when you tell us you'd like a man who'd love the job you'd give . . .

. . . there are things to do in our house.

There are things to do that call for all the patience, wit and maybe wisdom that we can summon to find from coast to coast *the person* who'd just suit you like you'd like to be suited.

Usually you ask for personnel with special training and then you pile on top of that a yearning for *regular* people, for folks who have a vital, eager way with them, for people to help you do the tasks of your hospital who'd do them willingly, *dependably*, with a song and a tune

in their minds, and earnestness in their hearts.

There are lots of folks like that. Most of those who come to us would fit in that warm definition. It's only needed that they find and work in the job they'd love; only needed that we find them square pegs or round pegs and fit them into square holes or round holes for the beginnings of lifetimes of happiness.

And if you write and tell us exactly the kind of a man or woman you want . . . we go to WORK in our house to find the peg who'd fit, fit pleasantly, happily, who'd fit squarely into square holes, roundly into round holes . . . and we'd send them on to you.

This is our great work; these things we do *well*.

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MODERN HOSPITAL WINDOWS

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Among the most modern general institutions of its kind is the St. Joseph's Hospital at Parkersburg, West Virginia, Architects Fox, Duthie & Foose. Its Colonial design is enhanced by the use of small paned, Fenestra Windows with Tilt-in ventilators at the sills and side-hung open-out swing leaves above. All window openings are screened. The many conveniences which these windows afford in the way of abundant ventilation, draft control, privacy, easy operation and lack of maintenance expense have made them an outstanding feature and a source of satisfaction to both patients and attendants. For details write, Detroit Steel Products Company, 2256 East Grand Boulevard, Detroit, Michigan.

BOOKS ON REVIEW

DAS KRANKENHAUS (The Hospital). By W. Alter, M.D. Stuttgart, Germany: Verlag W. Kohlhammer, 1936. Pp. 341. RM. 10 (price in Germany).

This book contains the articles of faith in the field of public health as conceived by a man of international reputation. As a credo of public health, the main sections of the book should be read by every person who aspires to work in any branch of public health.

The modern hospital with its out-patient departments has the opportunity of reaching a considerable part of the people at a time when they are most receptive to public health education. The organization and administration of the hospital should revolve around this goal. Otherwise the hospital becomes merely a repair shop. Ways and means toward this end are described by Doctor Alter in considerable detail.

Beginning with the position of the hospital in the general national economy and in the economy of public health, the author explains the functions of the hospital in its different departments and as executed by its various personnel groups; its relation to its environment, its construction and equipment. Construction and equipment are left to the last two chapters, and advisedly so: the hospital building should grow out of the idea and the functions of the hospital, not the reverse.

Although one may disagree with some administrative and other details, the book nevertheless is enormously rich in valuable suggestions which are difficult to find elsewhere. It does not supplant other books, quite the contrary. It deals with the philosophy of public health in the hospital; defines its application to the various phases of in and out-patient work, and specifies these details to a considerable extent. But it does not purport to be an administrative handbook like the excellent ones by Stone and MacEachern.

Doctor Alter's father was the medical chief of a large medical institution. Doctor Alter himself was born and raised in a hospital environment and is a graduate nurse as well as a doctor of medicine. He can look back upon a long career as chief physician and as administrator of various large hospitals. His consultant work covers every part of the hospital.

Observed deficiencies in hospital administration caused him to organize the German Advisory Council in Hospital Administration which has been responsible for many improvements in hospital work and has become a semi-official organization. One of the leaders in the International Hospital Association, he is the founder and chief editor of its journal, *Nosokomeion*. Finally, during the last few years, Doctor Alter has been a patient in seventeen hospitals in different countries. This book is the result of Doctor Alter's many experiences as nurse, physician, hospital administrator and patient.—GERTRUD KROEGER.

MAN IN A CHEMICAL WORLD. By A. Cressy Morrison. New York: Charles Scribner's Sons. 1937. Pp. 292. \$3.

The chemical industries tercentenary committee of the American Chemical Society, as its final act in completing the celebration of three centuries of chemical manufacture in America, presents this account of the activities of the chemical industry in converting the discoveries of science into the day-to-day necessities of life. Its purpose is to awaken in the mind of the lay reader a realization of the tremendous scope of the services rendered by the chemical industries.—JANE BARTON.

SURGICAL PRIDE



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The surgeon's responsibility to his patients is exceeded only by his satisfaction through the success of his skill.

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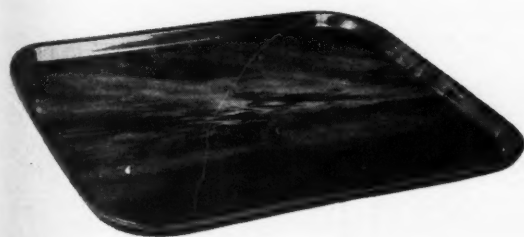
DO PATIENTS COMPLIMENT YOUR HOSPITAL?

Tempting dishes served on rich mahogany colored Boltalite trays impress both patients and visitors and bring many compliments to your staff. Always fresh and clean these trays win the approval of the most fastidious patients.

Boltalite trays contribute to comfort since they prevent disturbing noise in wards, corridors, on food carts

and in the kitchen. They cannot bang or clank when handled or stacked. The hard lustrous finish of these trays is permanent, germ and stain-proof and will not smut hands, linen or uniforms. Ask your equipment dealer for full information about these durable, economical trays, or use the convenient coupon below.

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Because of it, the patients have become more pleased with the coffee served to them. It has made the entire hospital routine seem brighter . . . more efficient . . . more careful.

One of our representatives will be glad to unfold this plan to you—or write today for complete details. There's no obligation, of course. Continental Coffee Company, Inc., 371-375 West Ontario Street, Chicago, Illinois.

CONTINENTAL COFFEE

America's Leading
Institutional Coffee



NEW PRODUCTS . . .

Protection Plus

The hand that rocks the cradle is no help to the patient whose bed covers are being supported by the said cradle. It's very easy to rock these cradles, too. They have a habit of skidding out of position with no provocation, and of making nuisances of themselves generally.

The Hill-Rom Company, Batesville, Ind., has been bothered about this for some time so it set to work to correct the situation. The result is the Protektent which, we are told, is much more than an improved cradle. Because of its construction and flexibility of adjustment, it is adaptable to a great many bed-patient needs. In addition to holding the bed covers away from burns, gangrenes and amputations, it can be used to suspend and support limbs, to cover and provide practical isolation of infectious cold cases in wards, as an oxygen tent, covered with transparent airtight fabric, or as a croup tent for inhalation.

The Protektent frame consists of three pieces. Two of the pieces are inverted U arches of square hollow tubing with a clamp riveted on each foot for fastening the arch to the side rail of the bed. One complete arch goes on each side of the bed, parallel to it. The horizontal top bar of the arch is formed of two pieces of tubing, one telescoping into the other to allow the sides of the arch to be made narrow or wide as desired. The uprights of the arch likewise have telescope joints and can be adjusted in height. The third piece is a flat grid, also expandable, which can be adjusted to the width of the supporting arches.

Pressing Made Perfect

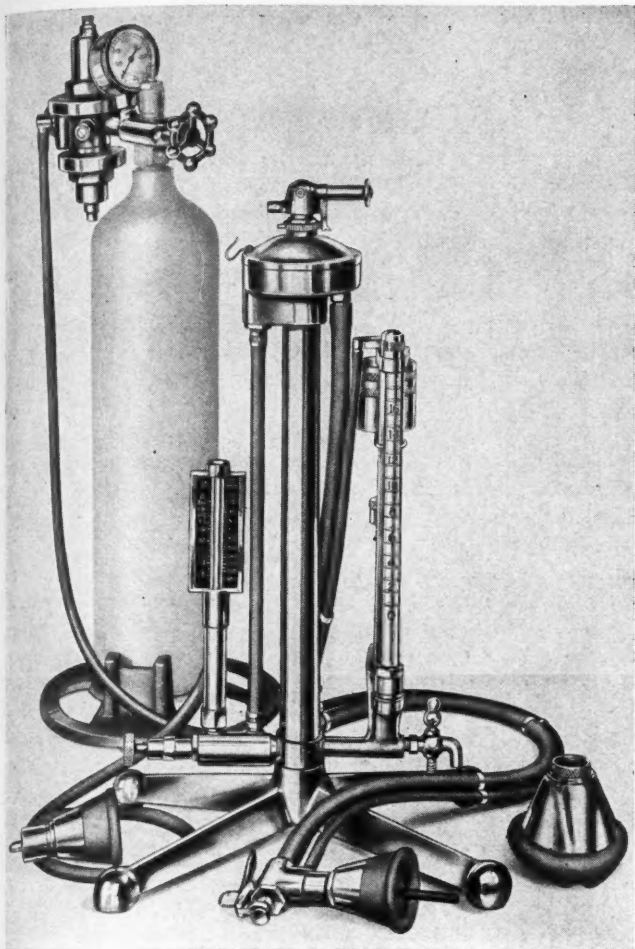
A pressing need has been solved by the introduction to the laundry world of the Tip-Top press, manufactured by the Troy Laundry Machinery Division of American Machine and Metals, 100 Sixth Avenue, New York. The Tip-Top, according to the manufacturers, takes the fatigue out of the press department. (Blimey! There won't be any excuse for anyone's being tired, pretty soon.) Control of the machine is by the feet and the pressing is entirely removed from the face and hands so that there is no danger of burns. The operator, sitting at ease in her chair, has her hands free to make the lays, assuring better results and speeding up production. She can turn from one press to the other in even motion, and there is no overpressing or oversteamed articles. When the pressing cycle ends, the head of the press lifts automatically and awaits the operator.

Talking Saves Walking

As an aid and uplift to walk-weary arches, we give you the nurse's signal phone equipment of the Dictograph Products Company, Inc., 580 Fifth Avenue, New York. This voice-to-voice communication system, in the words of the manufacturers, adds speedier room service, subtracts nurse fatigue and multiplies smiles and courtesy. It should, therefore, appeal to the calculating superintendent.

The operation of the signal phone is simplicity itself. The patient presses a button and then speaks, without raising his voice or changing his position. The signal is received by the instrument at the nurse's station directly above a switch key marked with the patient's room number. At the same time, the dome light goes on outside the pa-

WE ANNOUNCE



The Heidbrink RESUSCITATOR and INHALER

KREISELMAN MODEL

An apparatus which functions to accomplish the safe, convenient administration of resuscitative gases to still-born infants and to all patients whose breathing has ceased or is depressed, to create normal breathing for the former and restore it for the latter.

The Resuscitator and Inhaler has been offered to the profession only after careful research and study, and has built into it the scientifically accurate and dependable quality and the many exclusive features that have made all Heidbrink apparatus the recognized standard. Comes in Portable Models, Stand Models, Cart Models, and Electrically warmed Bassinet Models.

Our advance Bulletin giving prices and details will be sent upon request.

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● MOST authorities agree that the best way to eat, during hot weather, is a little and often. And menus should be light and easy to digest.

Kellogg's Corn Flakes are an ideal food for hot weather. They're crisp and refreshing in cool milk or cream. And they digest easily. Safe to serve at any time of the day.

Kellogg's, in the individual packages, are convenient, easy to serve. Order through any jobber. Made by Kellogg in Battle Creek.

Kellogg's
CORN FLAKES



- that there are nursing bottles made of glass that is heat and cold resistant
- that a six-sided nursing bottle is easier to hold
- that accurate ounce marks are important
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- that smoothly rounded interiors are easier to clean
- that only PYREX Brand Nursing Bottles possess all these features
- that PYREX Brand Nursing Bottles are made in two styles and two sizes — 8 oz. and 4 oz.
- that PYREX Brand Nursing Bottles are made to accommodate any standard type of nipple.



tient's room or the bull's-eye light above his bed if he is in a ward. The nurse throws the patient's key, picks up a handset and talks just as she does over other telephones. The microphone, it is claimed, picks up even the faintest whisper and the soft speaker reproduces the nurse's answer clearly and audibly.

Ice Tub That Pleases the Eyes

A handsome little item which will do its share toward dressing up your room service is the Chelsea Ice Tub constructed of black ebony composition, said by its makers, Chelsea Products, 281 Eleventh Avenue, New York City, to be practically indestructible. Originally designed for ice service, it has been found useful as a general container. Decalcomania designs of the hospital's name or coat-of-arms (a scalpel rampant on a blood red sponge, for choice) can be imprinted on the tub if one so desires.

Broken Bones Do Not a Prison Make

If anything in this changing world should be expected to remain stationary, it would be a fracture patient tied by the leg to his bed. But not so. Patient and bed can both go perambulating around the hospital whenever the need arises, owing to the thoughtfulness of the Montgomery Elevator Company, Moline, Ill., which has recently built an elevator car designed to accommodate the largest size of fracture bed, the patient and an attendant. One of these cars has been installed in the new wing of the Moline City Hospital and has already been found a great convenience in handling fracture beds. The car measures 6½ by 10½ feet. And this is no freight elevator, either. It is a modern passenger elevator decorated with beautiful cabinet work in oriental wood.

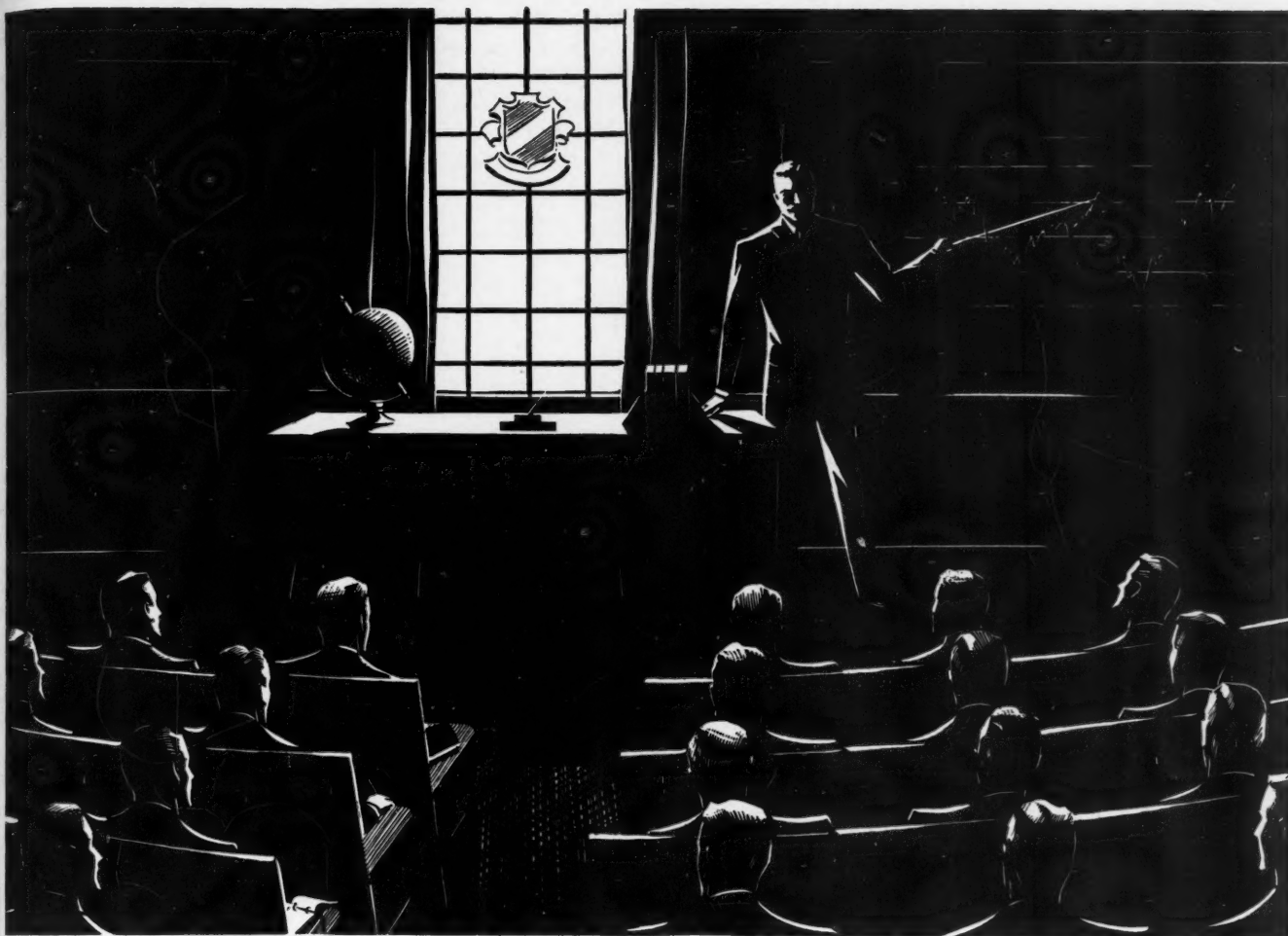
Thrifty Condensers; Spinning Coolers

A giant because it stands head and shoulders above other machines; Scotch because it is thrifty. That would seem to be the explanation of the name "Scotch Giant" bestowed on its new condensing unit by General Electric Company, Nela Park, Cleveland. This refrigerating machine ranges in size from ¼ to 50 H. P. The unit embodies many new features of design and construction and where it has been installed, it is stated that up to 50 per cent savings in operating costs can be effected.

General Electric's Commercial Division seems to be spreading itself these days. They are also calling attention to a new line of cooling units known to the trade as "spinner finned" and so called from the action of the liquid refrigerant as it passes through the tubing. The method of constructing the tubing is such that the liquid refrigerant spins or whirls through it, thereby increasing the velocity of the refrigerant which comes into contact with every part of the tubing.

Paging New Literature

Beauticians to the Building — "Beauty purveyors to the building industry" is a term that might well describe paint manufacturers since, as a preserver of the good looks of both women and buildings, a coat of paint rates highly indeed. Look at the money spent in America for cosmetics. Eagle-Ficher Sales Company, Temple Bar Building, Cincinnati, ranking cosmeticians in the building field, have issued a manual giving detailed data on the painting of interior and exterior woodwork, floors, plaster and wall boards, masonry and stucco, iron and steel and sheet metal



EDUCATION

Education is more than classroom exercise. In a broad sense, it is the development of all those natural faculties which dominate physical and mental character . . . Where physical education has been neglected as in the instance of constipation, wise counsel and selected treatment often expedite the return to normal function . . . As an adjunct to the treatment of diet and exercise, Petrolagar is

a useful and convenient method of correcting constipation . . . By its bland lubricating action, Petrolagar produces soft well formed stools which are easy to evacuate. Petrolagar is prepared in five types — Plain, with Phenolphthalein, with Milk of Magnesia, Unsweetened and with Cascara — to provide a range of treatment adaptable to the individual patient. Petrolagar Laboratories, Inc., Chicago, Illinois.



Petrolagar is a mechanical emulsion of pure liquid petrolatum (65% by volume) and agar-agar. Accepted by the Council on Pharmacy and Chemistry of the American Medical Association for the treatment of constipation.

Petrolagar

IS YOUR HOSPITAL SERVING THIS DRUGLESS CUP OF SLEEP?



HOSPITAL after hospital is supplying its patients a "night-cap" of hot Cocomalt and milk. They find this protective food drink helps induce sound sleep, is easily digested, quickly assimilated.

But more. Cocomalt helps build up the patient's strength because it supplies important food essentials. Iron for example. Each ounce-serving of Cocomalt provides 5 milligrams of effective Iron (biologically tested for assimilation)... enough iron to supply $\frac{1}{3}$ of the daily nutritional requirements of the normal patient.

Cocomalt is enriched with calcium and phosphorus, too, providing .15 gram of Calcium, .16 gram of Phosphorus per ounce-serving. And, to aid in the utilization of these food minerals, each ounce of Cocomalt also contains 81 U.S.P. Units of Vitamin D, derived from natural oils and biologically tested for potency.

The economical 5-lb. hospital size is available for professional use while the $\frac{1}{2}$ -lb. and 1-lb. purity-sealed cans of Cocomalt can be purchased at drug and grocery stores.

Cocomalt is the registered trade-mark of R. B. Davis Co., Hoboken, N. J.

| | 1 Ounce of Cocomalt adds | 1 Glass of Milk (8 Liquid Ozs.) contains | Result! 1 Glass of Cocomalt and milk contains |
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| IRON | 0.005 GRAM | *TRACE | 0.005 GRAM |
| VITAMIN D | 81 U. S. P. UNITS | *SMALL AMOUNT; VARIABLE | 81 U. S. P. UNITS |
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| PROTEIN | 4.00 GRAMS | 7.92 GRAMS | 11.92 GRAMS |
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*Normally Iron and Vitamin D are present in Milk in only very small and variable amounts.

†Cocomalt, the protective food drink, is fortified with these amounts of Calcium, Phosphorus, Iron and Vitamin D.

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Please send the free sample of Cocomalt you offer.

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work. There is also a fund of general information about the selection and proper application of paint. Formulas are given for various lead-in-oil paints, according to the type and conditions of the surface to be painted, with recommendations for preparation of the surface and other necessary instructions.

Unfortunately, the supply of these manuals is rather low, and they are available only to readers located in cities east of the Mississippi.

Furnishing Chemists' Paradise — In almost every chemistry laboratory there is at least one practical joker whose perverted sense of humor impels him to turn loose on his unsuspecting companions the more odoriferous gases, hydrogen sulphide, for choice. At such trying moments, the fume hood, designed to remove said gases with speed and dispatch, comes into its own. Blessings, therefore, on the man who invented fume hoods.

The Mathews individual hoods, presented in the new Leonard Peterson catalogue, represents a new and effective laboratory fume hood construction. It utilizes the principle of a high velocity flow through a narrow slot. Currents are so generated with the help of the canopy that, with as low as 150 cubic feet of air per minute, the hood is exceptionally effective in removing both heavy and light gases.

Of course, fume hoods are only one of many items of laboratory furniture which Leonard Peterson and Company, 1222 Fullerton Avenue, Chicago, are prepared to offer to interested parties. There are, among other things, biology tables, instructors' desks, cabinets, supply and apparatus cases, complete with all appurtenances thereto. The chemist who dreams of a laboratory fitted up just as he wants it would have a field day poring over this catalogue.

Superstition Canned — And another superstition bites the dust. Of course, most people nowadays have outgrown the fear of canned foods — particularly the idea that once a can has been opened, the food must be removed at once or it will spoil, with dire consequences to the digestive tract of anyone who eats it. However, if there are any last lingering doubts regarding canned foods, canned, that is, by professionals who have made a study of the business, let us recommend an attractive, well written book published by the American Can Company, 230 Park Avenue, New York, entitled "Nutritive Aspects of Canned Foods."

The book is a general summary of facts about tin containers and canned foods. It is divided into two sections, the first dealing with the preservation of foods, dietary requirements, the mineral and vitamin conservation in canned foods, infant nutrition, and the safety of canned foods under modern methods of packing. Section two takes up the manufacture of cans and discusses the canning procedure from the raw materials through the sealing of the cans and the heat processing.

Takes the Floor — Consider the floor in its downtrodden state; consider it well before it's too late. Sorry, we didn't mean to go poetic on you, but we are just passing on the warning of those inspired floor preservers, the Vestal Chemical Laboratories of St. Louis. Say they, with twenty-five years of experience to back them up, no part of any building gets so much rough usage as the floors, and serious thought, therefore, should be given to their proper treatment and care. Recommended by Vestal as excellent for floors are sundry floor seals, cleaning materials and waxes described in a new catalogue.

In addition to adequate care of floors, the catalogue brings to the attention of its readers the importance of sanitary soap service in public or semipublic washrooms. Vestal liquid soap dispensed from closed containers, of its own manufacture, is, this company avers, both sanitary and economical.